

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02507

## 2524 CERTIFICATE OF DEATH

Reg. Dist. No.....

Item 1, Film G194 3-21-56 et

1. PLACE OF DEATH- COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Lodge Forrest, Dist.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Moreland Nursing Home		STREET ADDRESS (If rural, give location) 317 S. Chapel Street	
3. NAME OF DECEASED (Type or Print)	(First) (Middle) (Last)	4. DATE OF DEATH	
Michalena (Lena)	Anuszewski (Anderson)	March 12 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
		Married	Sept 26, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE last birthday 64 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Lentz		14. MOTHER'S MAIDEN NAME Agnes Janowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. 216-05-1478	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Joseph Anuszewski 317 S. Chapel Street	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 9, 1956, to Mar. 12, 1956, that I last saw the deceasedalive on Mar. 12, 1956, and that death occurred at 6:10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

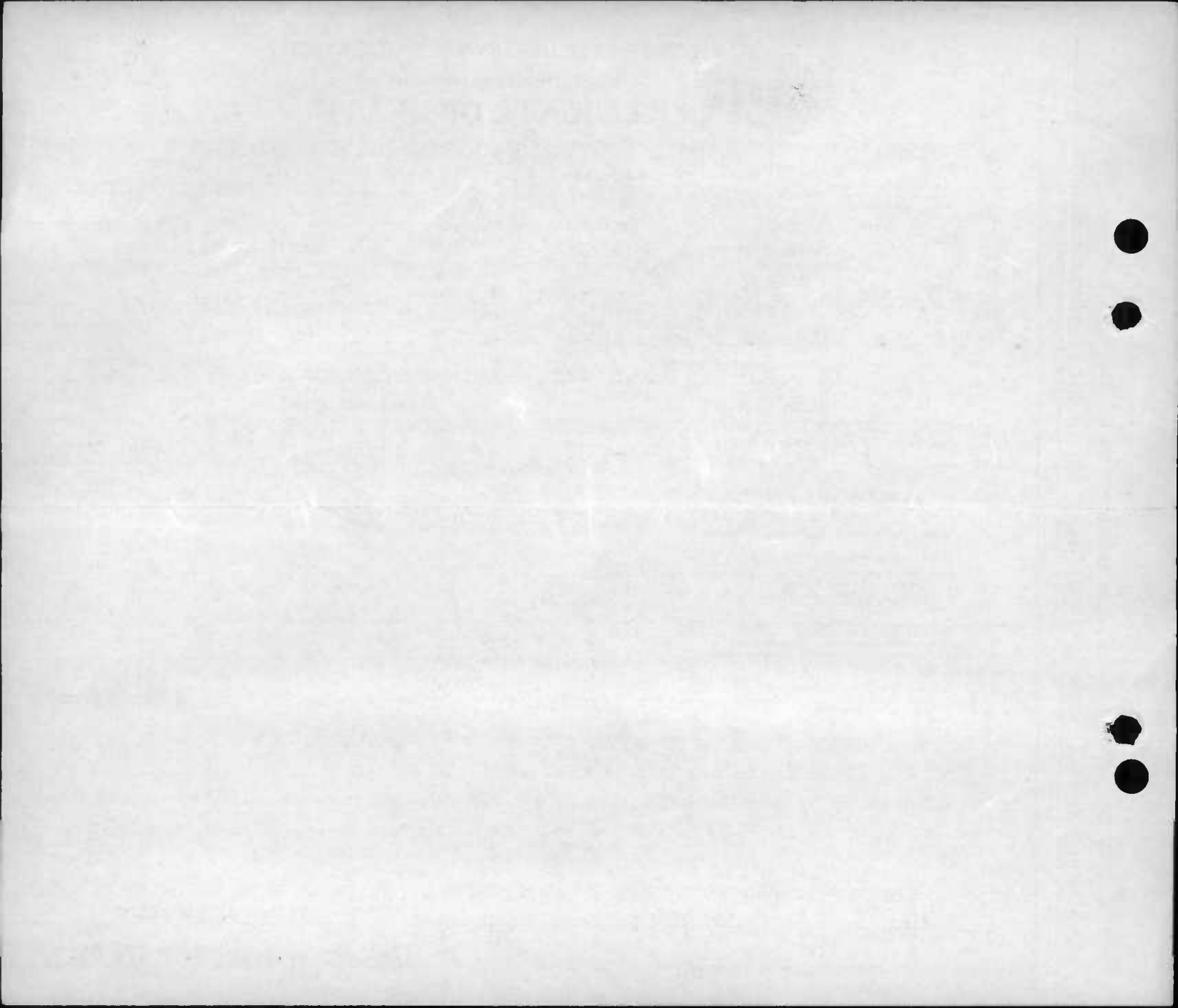
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	March 16, 1956	Holy Rosary	Baltimore, Maryland	

DATE REC'D BY LOCAL REG. 3-15-56 REGISTRAR'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc., 403 S. Wolfe St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Baltimore	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) 28 yrs	STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6905 5th. Ave.		STREET ADDRESS (If rural give location) 6905 5th. Ave.	
3. NAME OF DECEASED: (Type or Print) Joseph Thomas Alex		4. DATE (Month) (Day) (Year) OF DEATH: March 16, 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb. 9, 1904
		9. AGE last birthday 52 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): welder		10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel	11. BIRTHPLACE (State or foreign country): Sparrows Point, Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: George Alex		14. MOTHER'S MAIDEN NAME: Rose Baumgartner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: Clara Alex 6905 5th Ave. Dundak			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Occlusion			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 1955, to 3/16, 1956, that I last saw the deceased alive on 3/15, 1956, and that death occurred at 10:20 AM, from the causes and on the date stated above.			
SIGNATURE: Joseph R. Lohak		DATE SIGNED: 3/17/56	
ADDRESS: M. D. 3508 Bank St.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: March 19, 1956	
NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cemt		LOCATION (City, town, or county) (State): Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE: John A. Moran	
ADDRESS: 3000 E. Baltimore St			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL

MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]

6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

3-10-43

Very truly yours,  
[Illegible Signature]



**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02508

## 2525 CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>2 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	<u>0913.2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>6 Cedar Street</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>SAMUEL</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 26 1956</u>	
(First) (Middle) (Last) <u>ANDREWYWECH (ANDREWS)</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 13, 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pinsk, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Andrewywech</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
(If Yes, give war or dates of service) <u>WW I</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA, RIGHT UPPER AND LEFT LOWER</u>			UNKNOWN
ANTECEDENT CAUSE(S) (B) <u>LOBES</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CIRRHOSIS OF LIVER. 2. ARTERIOSCLEROTIC HEART DIS.</u>			UNKNOWN
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 24, 1956</u> , to <u>March 26, 1956</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Donald D. Mark</u>		ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>	
DATE <u>March 29, 1956</u>		DATE SIGNED <u>3/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	
25. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>			
26. REC'D BY REGISTRAR <u>March 29, 1956</u>		27. REGISTRAR'S SIGNATURE <u>Ramon L. Larter</u>	
28. FUNERAL DIRECTOR'S SIGNATURE <u>Re Compt</u>		ADDRESS <u>Le Compt Funeral Home, Cambridge, Md.</u>	

# CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF CHURCH OFFICIAL

20. SIGNATURE OF OTHER OFFICIAL

21. SIGNATURE OF OTHER OFFICIAL

22. SIGNATURE OF OTHER OFFICIAL

23. SIGNATURE OF OTHER OFFICIAL

24. SIGNATURE OF OTHER OFFICIAL

25. SIGNATURE OF OTHER OFFICIAL

26. SIGNATURE OF OTHER OFFICIAL

27. SIGNATURE OF OTHER OFFICIAL

28. SIGNATURE OF OTHER OFFICIAL

29. SIGNATURE OF OTHER OFFICIAL

BUREAU V. 2

MAR 09 1956

RECEIVED

2526

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLANDCITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE LENGTH OF STAY (in this place) 10 yearsHOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE ST. HAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Prince Georges  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CARMODY HILLS 16X-2STREET ADDRESS (If rural give location) ? ✓

## 3. NAME OF DECEASED:

(First) (Middle) (Last)

HOWARD ARRINGTON4. DATE (Month) (Day) (Year)  
OF DEATH: 3 / 3 19 56

## 5. SEX:

M

## 6. COLOR OR RACE:

W7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

## 8. DATE OF BIRTH:

3/3/1911

## 9. AGE last birthday

45 yrs.

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HRS.

Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

None

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

VIRGINIA

## 12. CITIZEN OF WHAT COUNTRY?

by birth

## 13. FATHER'S NAME:

WASHBURN ARRINGTON

## 14. MOTHER'S MAIDEN NAME:

MINNIE BASE

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Hospital Records

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260X

## IMMEDIATE CAUSE

(A) Diabetic Coma  
DUE TO

## ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Uremia  
DUE TO

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

## 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/6, 1945, to 3/3, 1956, that I last saw the deceased alive on 3/3, 1956, and that death occurred at 5<sup>55</sup> P M, from the causes and on the date stated above.

SIGNATURE

JRCowen

ADDRESS

M.D. Spring Grove Hosp.

DATE SIGNED

3/3/56

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county) (State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

3/4/56T.E. HarryR.S. Hall - 2200 17th Ave. N.W. - Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 6 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2519

## CERTIFICATE OF DEATH

### 02510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4106 Leeds Ave.</b>				d. STREET ADDRESS <b>4106 Leeds Ave</b>			
3. NAME OF DECEASED (Type or print) <b>William P. Bach</b>				4. DATE OF DEATH <b>3-14-56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1876</b>	
9. AGE (In years birth day) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired silversmith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steff Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>Howard Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>216-07-8740</b>			
17. INFORMANT <b>Lawrence Bach</b>				Address <b>4106 Leeds Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular</b> (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Aug 1955</b> to <b>March 14, 1956</b> , that I last saw the deceased alive on <b>March 14, 1956</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. EARL PASS, M.D.</b>				ADDRESS (Street, city or town, state) <b>4001 Wilkens Ave Baltimore</b>			
PHYSICIAN'S NAME (Type) <b>T. EARL PASS, M.D.</b>				DATE SIGNED <b>3-16-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Arcadia, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR <b>Dr. Geo. J. M. Kupper</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BATH ONE 78

## CERTIFICATE OF DEATH

**RECEIVED**  
 MAR 19 1956  
 BUREAU V. S.

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "March 15, 1956"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "C. D. Brown"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	

2527

## CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2, File G194 3-21-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 7th</u>	LENGTH OF STAY (in this place) <u>2 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 29th</u>	<u>301-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robt Nursing Home, Essex St</u>		STREET ADDRESS (If rural give location) <u>4219 Vermont Avenue</u>	
3. NAME OF DECEASED: (Type or Print) <u>Thomas Bruce Baldwin</u>	(First) (Middle) (Last)	4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 8 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Nov. 6, 1898</u>
9. AGE last birthday: <u>57 yrs.</u>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk retired Gps &amp; Electric Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Thomas Clinton Baldwin</u>		14. MOTHER'S MAIDEN NAME: <u>Amanda McDonald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-4197</u>	
17. INFORMANT & ADDRESS: <u>Mrs. J. B. Baldwin 4219 Vermont Ave. Baltimore 29th</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Arteriosclerotic heart disease</u>	
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>8 Jan.</u> , 19 <u>56</u> , to <u>8 Mar.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Mar.</u> , 19 <u>56</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.				
SIGNATURE <u>Paul H. Royce</u>		ADDRESS <u>Pikesville 8th</u>		DATE SIGNED <u>8 Mar 56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 10/56</u>	NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
DATE REC'D BY LOCAL REGISTRAR <u>3-9-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Harry H. Witzke</u> ADDRESS <u>4101 EDMONDSON AVE</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the certificate has been signed by the attending physician and carefully filled in by the general director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02512

2528

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8401 Harford Road #14</b>		d. STREET ADDRESS <b>8401 Harford Road #14</b>	
3. NAME OF DECEASED (Type or print) First <b>Mr. Samuel</b> Middle <b>Jennings</b> Last <b>Bateman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/31/1897</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD Md. PENN.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL BATEMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET O'LEARY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213 20 6206</b>	
17. INFORMANT <b>Mrs. Ann M. Bateman</b>		Address <b>8401 Harford Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular</b> DUE TO (c) <b>Renal Disease &amp; Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5-October</b> <b>1953</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-Oct., 1953</b> to <b>19-Mar., 1956</b> , that I last saw the deceased alive on <b>19-Mar., 1956</b> , and that death occurred at <b>1030 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas W Edmonds</b> M.D.		ADDRESS (Street, city or town, state) <b>2746 The Alameda Balto-18-Md</b>	
PHYSICIAN'S NAME (Type) <b>Chas. W Edmonds M.D.</b>		DATE SIGNED <b>19-Mar-1956</b>	
22a. BURIAL-CREMATATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/22/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London PARK</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>DATE 3/21/56</b>	
24b. REGISTRAR'S SIGNATURE			

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MAR 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02513  
43

2529

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>			c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Joppa Road</b>				d. STREET ADDRESS <b>Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY E. BEALL</b> Middle Last				4. DATE OF DEATH Month <b>March</b> Day <b>15th</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1882</b>		9. AGE (In years lost birthday) <b>74 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Francis</b>				14. MOTHER'S MAIDEN NAME <b>Emma V. Henry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Dallas I. Beall, Joppa Rd., Fullerton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremic COMA - UREMIC PERICARDITIS</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF LEFT BREAST C</b> DUE TO <b>(4-5 YRS)</b> (c) <b>METASTASIS TO BRAIN, LYMPH NODES &amp; LIVER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1, 1955</b> to <b>MAR 15, 1956</b> , that I last saw the deceased alive on <b>MAR 15, 1956</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3009 EVERGREEN AVE BALDRI4</b> DATE SIGNED <b>3/16/56</b>							
ACTUAL SIGNATURE <b>Donald W. Muntzer</b>		PHYSICIAN'S NAME (Type) <b>DONALD W. MUNTZER</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>2/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Camp Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fullerton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lashon Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>March 20, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. H. L. Henderson</b>			

MAR 20 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02514

Reg. Dist.

No. 33

1. PLACE OF DEATH: COUNTY <b>Baltimore</b> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Westminster Rural</b> TOWN <b>Westminster Rural</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Westminster Road</b>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>Carroll</b> CITY (If outside corporate limits write RURAL and give nearest town) <b>Westminster</b> TOWN <b>Westminster</b> STREET ADDRESS (If rural, give location) <b>Westminster</b>			
3. NAME OF DECEASED: (Type or Print) <b>James Henry Beaver</b>		(First) (Middle) (Last)		4. DATE OF DEATH <b>March 11, 19 56</b>			
5. SEX: <b>M.</b>	6. COLOR OR RACE: <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>Dec. 25, 1907</b>			
9. AGE last birthday: <b>48</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <b>Labor for Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country): <b>USA</b>				12. CITIZEN OF WHAT COUNTRY: <b>USA</b>			
13. FATHER'S NAME: <b>Granville Beaver</b>				14. MOTHER'S MAIDEN NAME: <b>Evelyn M. Reynull</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>yes</b>		(If Yes, give war or dates of service) <b>W.W. II</b>		16. SOCIAL SECURITY No.: <b>219-01-2026</b>			
17. INFORMANT & ADDRESS: <b>Joseph H. Beaver R.F.D. Westminster, Md</b>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause (a) <b>Fractured Skull(base)</b> DUE TO  Antecedent cause(s) (b) <b>Compound Fracture Rt. Leg</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)  II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>					INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>  <b>immediate</b>		
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION: <b>none</b>					
20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <b>Westminster Rd., Reisterstown, Balto., Md.</b>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>3-11-56 11:12 P.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Struck by automobile</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>D. H. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-12-56</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>3-14-56</b>		NAME OF CEMETERY OR CREMATORY <b>Daer Park</b>			
LOCATION (City, town, or county) (State) <b>Carroll Co. Md.</b>							
DATE REC'D BY LOCAL REG. <b>3-12-56</b>		REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		24. FUNERAL DIRECTOR <b>H. Bankard &amp; Sons</b> ADDRESS <b>Westminster, Md.</b>			

33

BUREAU V. S.

MAR 16 1956

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3-15-56 (28) 100



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02515

2531

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>03</u> <u>1002 N. Rolling Rd.</u>		STREET ADDRESS (If rural give location) <u>1</u> <u>1002 N. Rolling Rd.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>GEORGIE</u>		(Middle) <u>SWOPE</u>		(Last) <u>BENJAMIN</u>		(Month) <u>Mar.</u> (Day) <u>31</u> (Year) <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 7, 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Swope</u>				14. MOTHER'S MAIDEN NAME <u>Susanna Boyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Wm. A. Milby-3614 Hillsdale Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
I <u>422.1</u> IMMEDIATE CAUSE (A) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Virus pneumonia 1 month ago</u>				<u>1-</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Tue</u> , 19 <u>54</u> , to <u>Mar. 3, 19 56</u> , that I last saw the deceased alive on <u>Mar. 31, 19 56</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Nathaniel M. Beck</u>		DATE THEREOF <u>4/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem.</u>		LOCATION (City, town, or county) (State) <u>Gettysburg, Penna.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>APR 3 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekens &amp; Sons</u>		ADDRESS <u>Balto 17 Md</u>	

BUREAU V. S.

APR 3 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02516

2520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Ashburton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Ashburton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 709 Maiden Church Lane</u>		d. STREET ADDRESS <u>709 Maiden Church Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie M Biermann</u>		4. DATE OF DEATH Month Day Year <u>Mch 6 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 1887</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home duties</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hanen</u>		14. MOTHER'S MAIDEN NAME <u>An + Knw</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>100-1-10000</u>	
17. INFORMANT <u>Joseph Biermann Maiden Church Lane</u>		Address <u>709 Maiden Church Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4.22.1</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary vascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>for</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gertrude Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gertrude Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. LOCATION (City, town, or county) <u>Balto Md</u>		DATE SIGNED <u>Mch 6 56</u>	
22c. DATE THEREOF <u>March 9 1956</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. M. Walters</u>		24a. REC'D BY REGISTRAR <u>Dr. Geo. S. M. Kieffer</u>	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

MAR 7 1956

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_  
2. SEX: \_\_\_\_\_  
3. AGE: \_\_\_\_\_  
4. RACE: \_\_\_\_\_  
5. OCCUPATION: \_\_\_\_\_  
6. PLACE OF BIRTH: \_\_\_\_\_  
7. DATE OF BIRTH: \_\_\_\_\_  
8. DATE OF DEATH: \_\_\_\_\_  
9. TIME OF DEATH: \_\_\_\_\_  
10. PLACE OF DEATH: \_\_\_\_\_  
11. CAUSE OF DEATH: \_\_\_\_\_  
12. MANNER OF DEATH: \_\_\_\_\_  
13. SIGNATURE OF EXAMINER: \_\_\_\_\_  
14. SIGNATURE OF WITNESS: \_\_\_\_\_  
15. SIGNATURE OF CORONER: \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH

02517

2411 N. Charles Street, Baltimore

2532

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
TOWN <u>CARNEY</u>		TOWN <u>CARNEY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9907 HARFORD RD</u>		STREET ADDRESS (If rural, give location) <u>9907 HARFORD RD</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>N</u> (Middle) <u>Billingsley</u> (Last)		4. DATE OF DEATH <u>MARCH</u> (Month) <u>17</u> (Day) <u>1956</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. <del>SINGLE</del> , MARRIED, <u>WIDOWED</u> , DIVORCED, (Specify)	8. DATE OF BIRTH <u>APRIL 5, 1884</u>
			9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Billingsley</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA HENRY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-10-7615</u>	
		17. INFORMANT <u>LLwood Billingsley</u> <u>9907 Harford Rd</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>	<u>1 wk</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>	
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to Mar, 1956, that I last saw the deceased alive on Mar 10, 1956, and that death occurred at 7:00 m., from the causes and on the date stated above.

SIGNATURE <u>Frank P. Kasik, Jr.</u>	(Degree or title)	ADDRESS <u>9005 Harford Rd</u>	DATE SIGNED <u>3/17/56</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>March 20, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Harford</u>	LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>
DATE RECD BY LOCAL REG. <u>3/21/56</u>	REGISTRAR'S SIGNATURE <u>A.M. Bacon</u>	24. FUNERAL DIRECTOR <u>Chas. F. Evans &amp; Son</u>	ADDRESS <u>8802 Harford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2533 CERTIFICATE OF DEATH

02518

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills, Md.</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington 23, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>4627 Newell Lane, S. E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Russell</u> Last <u>Bingaman</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/28/49</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey Russell Bingaman</u>		14. MOTHER'S MAIDEN NAME <u>Lois Elizabeth Glazier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Rosewood Records</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Aspiration Pneumonia (both sides)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spastic Quadriplegia</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 3, 19 55</u> , to <u>March 31, 19 56</u> , that I last saw the deceased alive on <u>March 31, 19 56</u> , and that death occurred at <u>10:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlos E. Arrabal</u>		DATE SIGNED <u>4/2/56</u>	
PHYSICIAN'S NAME (Type) <u>Carlos E. Arrabal, M. D.</u>		ADDRESS (Street, city or town, state) <u>2920 N. Calvert St., Baltimore 18, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 5-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rock</u>		22d. LOCATION (City, town, or county) (State) <u>Jewistown Mifflin Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer Sons Rustertown</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>4-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

BUREAU V. S.

APR 4 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2534 CERTIFICATE OF DEATH

02519

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> 1.m.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 02-10-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Spring Grove Hospital</u>				d. STREET ADDRESS <u>916 Bay Ridge Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Blades</u>				4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>56</u> 19			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1874</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records of Spring Grove Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Decompensatory heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>  <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary abscess</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2.26</u> , 19 <u>56</u> to <u>3.26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-26-</u> , 19 <u>56</u> , and that death occurred at <u>8.30P</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u>		DATE SIGNED <u>3-27-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Court</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tyler + sons</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>	

APR 2 1955

RECEIVED



## 2535 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shady Nook Nursing Home</u> <u>1002 N. Rolling Rd.</u>		STREET ADDRESS (If rural give location) <u>4105 Liberty Heights Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>MARY</u>	(Middle) <u>AGNES</u>	(Last) <u>BLOMGREN</u>	OF DEATH: <u>Mar. 8, 1956</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Apr. 7, 1893</u>
9. AGE last birthday <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Timothy O'Flaherty</u>		14. MOTHER'S MAIDEN NAME: <u>Bridget Quinlan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-28-3193</u>	
17. INFORMANT & ADDRESS: <u>Mr. George McManus, Jr-10 Light St.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
157X IMMEDIATE CAUSE (A) <u>Carcinoma of Pancreas</u>			<u>14 days</u>
ANTECEDENT CAUSE (S) DUE TO <u>Pneumo - pneumonia</u>			<u>1 week</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>11/10/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Pancreas</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>3/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>56</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. J. Lickner</u>		DATE SIGNED <u>3/9/56</u>	
M. D. <u>1115 St. Paul St. Balt.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/10/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons - Balt.</u>		ADDRESS <u>17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02521

2536

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 Catonsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Balto.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>16 Fusting Ave.</b>				STREET ADDRESS (If rural give location) <b>1218 E. North Ave.</b>			
3. NAME OF DECEASED: (First) <b>MARY</b> (Middle) <b>ELIZABETH</b> (Last) <b>BOTELER</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Mar. 5, 1956</b>			
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>Sept. 20, 1889</b>	9. AGE last birthday <b>66</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rtd.</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>Post Office</b>		11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <b>John McHugh</b>				14. MOTHER'S MAIDEN NAME: <b>Catherine Agnes Coffay</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service) <b>--</b>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Miss Elizabeth G. McHugh-1218 E. North Av</b>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Arteriosclerotic Ht Disease</b>							<b>1 year</b>
ANTECEDENT CAUSE (B) <b>Diabetes Mellitus</b>							<b>10 years</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9am</b> , 19 <b>55</b> , to <b>3.5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/3</b> , 19 <b>56</b> , and that death occurred at <b>7a</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Sol Smith</b>		M. D. <b>2500 E. North Ave.</b>		DATE SIGNED <b>Mar 17 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3/7/56</b>		NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>3/5/56</b>		REGISTRAR'S SIGNATURE <b>Dr. H. H. H. H.</b>		24. FUNERAL DIRECTOR <b>Thos. J. Lickner &amp; Sons</b>		ADDRESS <b>Balto 17 Md</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

IN SENATE  
January 10, 1917

REPORT OF THE  
COMMISSIONER OF HEALTH  
ON THE  
MORBIDITY AND MORTALITY  
IN THE STATE OF NEW YORK  
FOR THE YEAR 1916

ALBANY: J.B. LIPPINCOTT COMPANY, 1917.

## 2537 CERTIFICATE OF DEATH

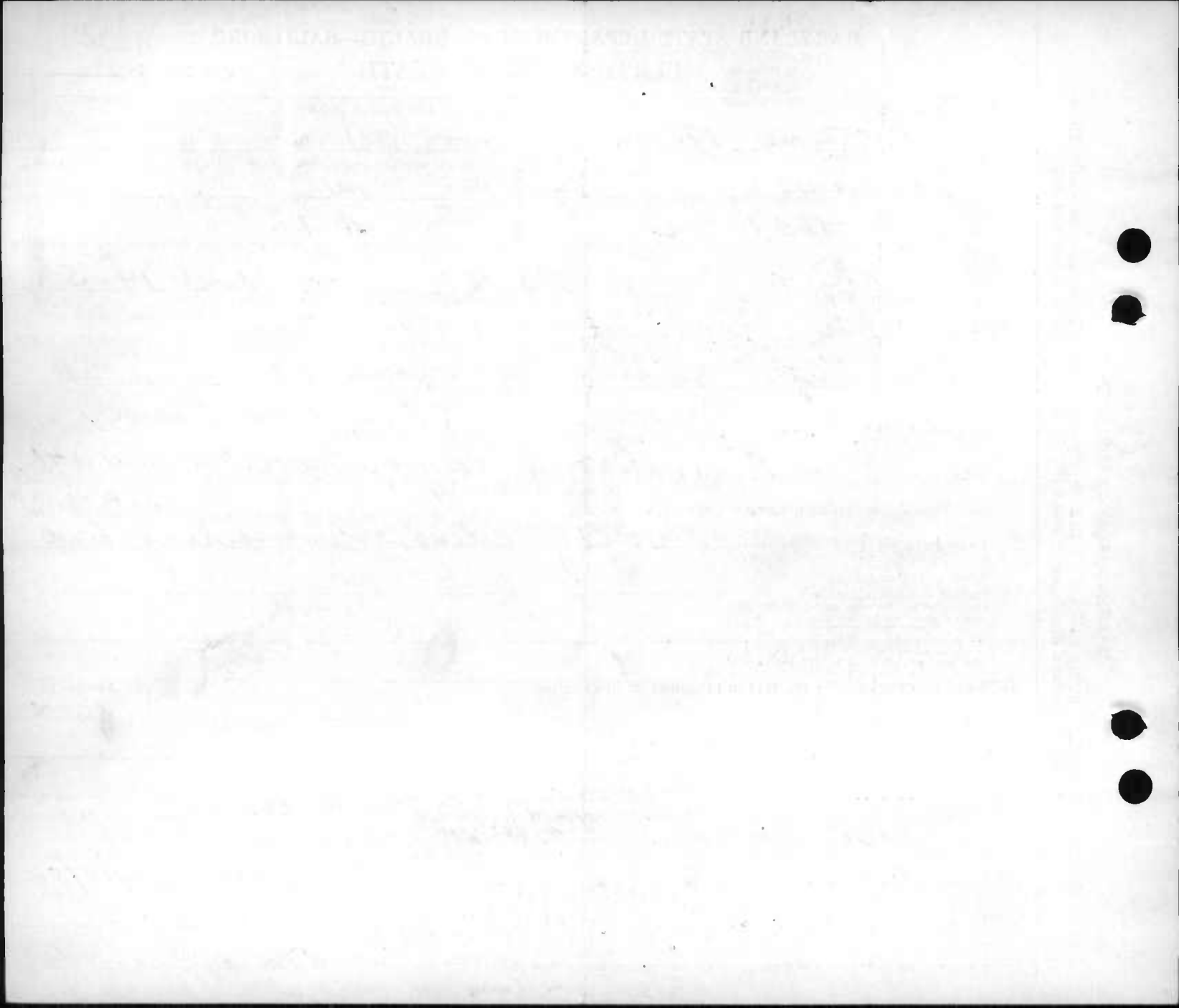
Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore 19.</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN</u> <u>Sparrows Pt.</u>		LENGTH OF STAY (in this place) <u>35 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN</u> <u>in</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Todd ave.</u>				STREET ADDRESS <u># 1.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Phillip Henry BOWER</u>				4. DATE OF DEATH: <u>March 14 19 56</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Feb. 10. 1880</u>	
9. AGE last birthday: <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>merchant marine</u>		11. BIRTHPLACE (State or foreign country): <u>Floyd. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Bower</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Mary Bower</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No.: <u>217-01-2887A</u>		17. INFORMANT & ADDRESS: <u>Clayton Bower (address as in #1)</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>163X</u> <u>Primary adenocarcinoma lung</u> <u>6 mo.</u>							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
SUICIDE		HOMICIDE		INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Sept 7, 19 55</u> to <u>Mar 14, 19 56</u> , that I last saw the deceased alive on <u>Mar 13, 19 56</u> , and that death occurred at <u>4:30 A</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Louis N. Tollin, M.D.</u>				(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>6908 North P+ Rd Balto 19. Md</u>	
DATE SIGNED <u>3/14/56</u>		DATE THEREOF <u>Mar 16 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>3-15-56</u>		REGISTRAR'S SIGNATURE <u>W. Hedrick</u>		24. FUNERAL DIRECTOR <u>William Funeral Home</u>		ADDRESS <u>2112 Sandath</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2538

02523

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Michigan</b>		COUNTY <b>Wayne Co.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN <b>Reisterstown</b>		<b>traveling</b>		TOWN <b>Detroit</b>		<b>59x-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Hanover Rd.</b>				STREET ADDRESS (If rural, give location) <b>13129 Menbota Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)			
(Type or Print) <b>Karl H. Broker</b>		<b>March 18</b>		<b>19 56</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Divorced</b>	<b>Sept. 21, 1888</b>	<b>67</b>	yrs. Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Insurance broker</b>		<b>Insurance broker</b>		<b>Rome, N.Y.</b>		<b>U.S.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Frank Broker</b>				<b>Barbara Oeinch</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<b>No</b>				<b>1721 Seymour Ave. Mrs. Wilson D. Feistal Utica, 3 N.Y.</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<b>260x</b> Immediate cause (a) <b>Coronary Occlusion</b> DUE TO						<b>10 min.</b>	
Antecedent cause(s) (b) <b>Diabetes</b> Diseases or conditions, if any, giving rise to the above cause DUE TO						<b>1 wk.?</b>	
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY?	
<b>none</b>		<b>none</b>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>none</b>		21c. (City or town) (County) (State)			
<b>none</b>		<b>none</b>		<b>none</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>			
<b>none</b>		<b>none</b>		<b>none</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>D. D. Caples</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-19-56</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Mar. 21, 1956</b>		<b>Rome Cemetery</b>		<b>Rome, N.Y.</b>	
DATE REC'D BY LOCAL REG. <b>3-18-56</b>		REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

MAR 21 1956

RECEIVED



2539

## CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>16 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5215 Old Frederick Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES - RONALD BROWN</b>		4. DATE OF DEATH <b>MAR 28 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 16, 1891</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marine Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Harrisburg Pa</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William L. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Arnold</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Anna E. Brown</b>		Address <b>5215 Old Frederick Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>442X</b> DUE TO (b) <b>Advanced hypertensive + arteriosclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>cardiac vascular - renal disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 or 3 days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 Jan, 1951</b> to <b>28 Mar, 1956</b> , that I last saw the deceased alive on <b>28 Mar, 1956</b> , and that death occurred at <b>9:10 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Emil H Henning Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>601 Winans Way</b>	
PHYSICIAN'S NAME (Type) <b>EMIL H HENNING JR</b>		DATE SIGNED <b>29 Mar 56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 31/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Geufel</b> ADDRESS <b>5311 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>RR 4</b> 24b. REGISTRAR'S SIGNATURE <b>J. E. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02525

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore County</u> <u>Bethlehem Steel Co. Dispensary</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1001 K St. Sparrow Pt.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JAMES</u> <u>BROWN</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>3-8-56</u> <u>19</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 6, 1896</u>		<b>9. AGE</b> (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mouldman Helper</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Cumberland Co. Va.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Washington Brown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie Randolph</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Marylou Williams Farmville Va.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardia-Vascular Disease with auricular fibrillation.</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>5 or 6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>NONE</u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>													
<b>ACTUAL SIGNATURE</b> <u>M B Davis</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>M. B. Davis</u> M.D.						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>3/9/56</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>				<b>22b. DATE THEREOF</b> <u>March 13/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Farmville Va.</u>				<b>22d. LOCATION</b> (City, town, or county) (State)			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mrs. Robert A. Elliott &amp; Co.</u>						<b>ADDRESS</b> <u>1129 N. Charles St.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Dawson L. Farber</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DENTIST		25. SIGNATURE OF OTHER	
26. SIGNATURE OF CHURCH		27. SIGNATURE OF SCHOOL		28. SIGNATURE OF BUSINESS		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER	
86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER	
96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

RECEIVED  
MAR 14 1904  
BUREAU  
BUREAU V. S.

## 2521 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 Halethorpe</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>51 Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2024 Northeast Ave.</u>		STREET ADDRESS (If rural give location) <u>2024 Northeast Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>James M. Bryde</u>		<u>Mar. 22, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Widower</u>	8. DATE OF BIRTH: <u>May 26, 1874</u>
9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or retired): <u>Porter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hotel (ret.)</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-10-2127</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Mary Glasgow</u>		<u>2024 Northeast Ave. Halethorpe, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Mitral Insufficiency</u>			<u>4 mo. 18 days</u>
ANTECEDENT CAUSE (S) DUE TO <u>Hypertensive Arterio-sclerotic</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Cardio-Renal Disease</u>			<u>?</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>II-6</u> , 19 <u>55</u> to <u>3-22</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3-22</u> , 19 <u>56</u> , and that death occurred at <u>3.00PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. F. Maloney</u>		DATE SIGNED <u>57</u> ADDRESS <u>Winters Land</u>	
		M. D. <u>Catonsville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>3/26/1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mt. Auburn</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>MAR 26 1956</u>		<u>Holland Funeral Home</u>	
		<u>1631 Druid Hill Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 29 1956

RECEIVED



2541

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Charles</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>50 Catonsville</b>		LENGTH OF STAY (in this place) <b>Byrs 3mths 29 dys.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Indian Head, Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>14 SPRING GROVE STATE HOSP.</b>				STREET ADDRESS (If rural give location) <b>Indian Head, Maryland 08X-2 ✓</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <b>Florence</b> (Middle) <b>M</b> (Last) <b>BUCK</b>				DATE OF DEATH: <b>March 4, 19 56</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>female</b>	<b>white</b>	<b>married</b>	<b>Nov. 12, 1898</b>	<b>57</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME: <b>Oliver Wanner</b>				14. MOTHER'S MAIDEN NAME: <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT & ADDRESS: <b>Records Spring Grove State Hospital</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebrovascular accident</b>						<b>1 week</b>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Hypertensive cardiovascular disease</b>						<b>Years</b>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 5</b> , 19 <b>56</b> , to <b>March 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 4</b> , 19 <b>56</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>JR. Brown</b>		M. D. <b>Spring Grove Hospital</b>		DATE SIGNED <b>3/4/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3/7/56</b>		NAME OF CEMETERY OR CREMATORY <b>MT Rest</b>		LOCATION (City, town, or county) (State) <b>Tall Gate, Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>3-7-56</b>		REGISTRAR'S SIGNATURE <b>T.E. Harris</b>		24. FUNERAL DIRECTOR <b>The funeral home</b>		ADDRESS <b>md</b>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 9 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02528

## 2542 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY <u>Towson</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1844 Yakona Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY <u>Towson</u> (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u> STREET ADDRESS <u>1844 Yakona Rd</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Decatur</u> (First) <u>H.</u> (Middle) <u>BURNETTE</u> (Last)		4. DATE OF DEATH <u>3-11</u> (Month) <u>1956</u> (Day) (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-17-1877</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Bristol, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Decatur Burnette</u>		14. MOTHER'S MAIDEN NAME <u>Sarah N. Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Mrs. B. Burnette, 1844 Yakona Rd, Towson 4, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arterio-sclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 29, 1952</u> , to <u>Mar 10, 1956</u> , that I last saw the deceased alive on <u>Dec 29, 1952</u> , and that death occurred at <u>7 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Lee K Fargo</u>		DATE SIGNED <u>3-11-56</u>	
ADDRESS (Street, city, town, state) <u>M.D. 8155 Loch Raven, Towson 4, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3-14-56</u>	NAME OF CEMETERY OR CREMATORY <u>Ordways Cemetery</u>	LOCATION (City, town, or county) (State) <u>Bristol, Tenn.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Metel Gray</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Ave.</u>	
DATE <u>MAR 12 1956</u>			

# CERTIFICATE OF DEATH

REGD. DEPT. 100

DEATH RECORDS - JUNE 1956

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

US BIRTH: [illegible]

US CITIZENSHIP: [illegible]

DATE OF ENTRY: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

BUREAU V. 3

MAR 12 1956

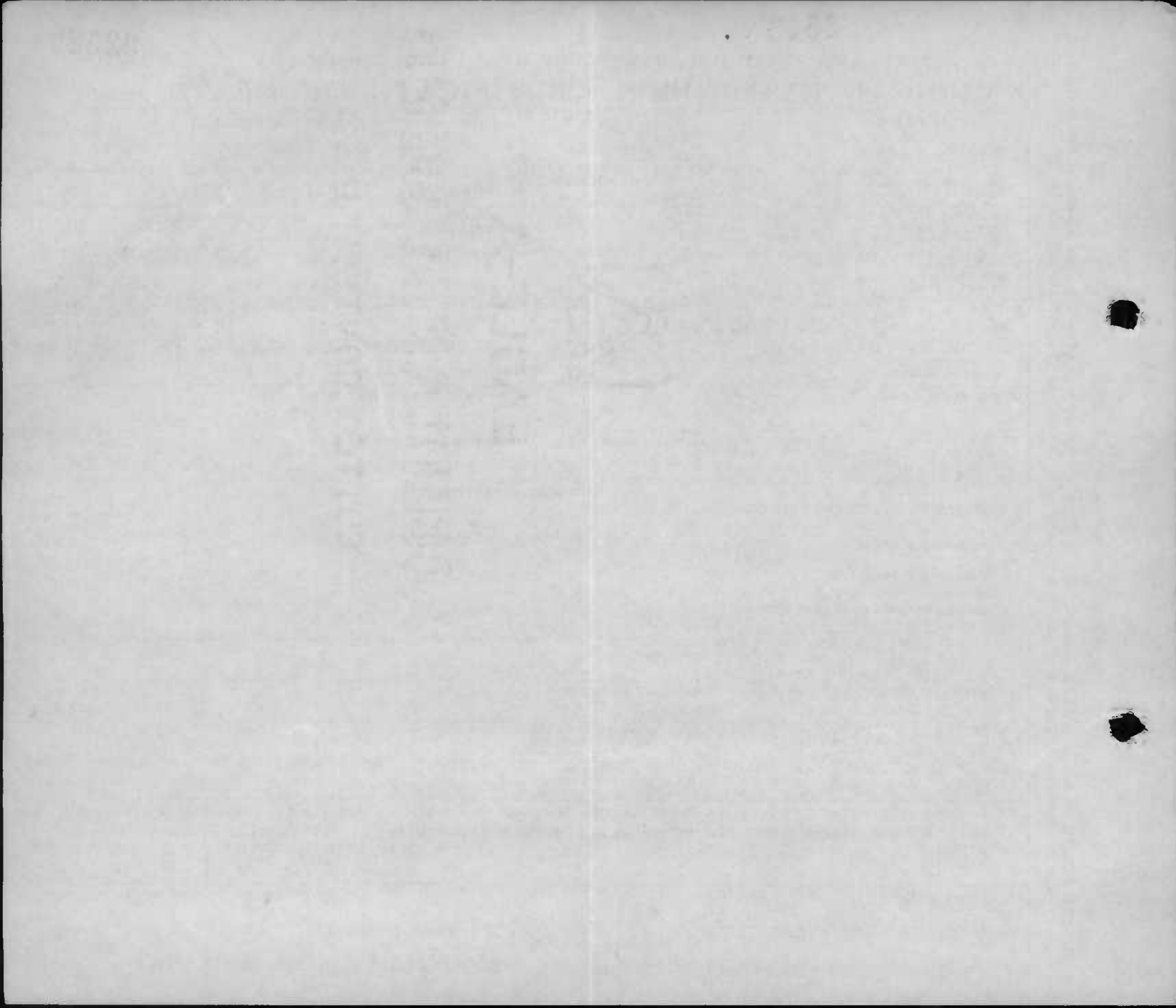
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02529  
Reg. Dist.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) * TOWN <i>Roundallstown</i>	LENGTH OF STAY (in this place) <i>8 yrs</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Roundallstown, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Zimmer Rd.</i>		STREET ADDRESS (If rural, give location) <i>Zimmer Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>DOROTHY BUTLER</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>3 12 19 56</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Dec 15, 1908</i>
9. AGE last birthday: <i>47</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife Home</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Sczepanski</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Bernack</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY No.: <i>218-34-0334</i>	
17. INFORMANT & ADDRESS: <i>Mary Catherine Butler Roundall</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <i>Coronary Occlusion</i>			<i>1/2 hr.</i>
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>None.</i>			
19a. DATE OF OPERATION: <i>None</i>		19b. MAJOR FINDING OF OPERATION: <i>None</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>	21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY <i>None</i>	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i> M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>None</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>A.D. Caples</i>		M. D. <i>3-12-56</i>	
23. BURIAL, CREMATION, REMOVAL, (Specify): <i>Burial</i>		DATE THEREOF <i>3/16/56</i>	
NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE REC'D BY LOCAL REG. <i>3-12-56</i>		REGISTRAR'S SIGNATURE <i>John Stansbury</i>	
24. FUNERAL DIRECTOR <i>John Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd 7.</i>	





2544

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTOWN BALTO 19MD. 2 weeks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER 06X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 WESTSHIRE, RD</u>				d. STREET ADDRESS <u>SANDYVILLE FINKSBURG, MD.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>KATIE</u> Last <u>CAPLE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 2, 1878</u>	9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>GEORGE W. ZEPP</u>			14. MOTHER'S MAIDEN NAME <u>MARY GEMISON</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Melvin Schaefer 309 Westshire Rd. Baltimore 19 Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X TERMINAL PNEUMONIA</u> DUE TO (b) <u>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>POSS. CEREBRAL METASTASIS - CA BREAST</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 "</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUG</u> , 19 <u>55</u> , to <u>MARCH 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 2</u> , 19 <u>56</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. W. Schaefer</u>			ADDRESS (Street, city or town, state) <u>3921 Edmondson Ave. Balt. Md.</u>			DATE SIGNED <u>3/4/56</u>	
PHYSICIAN'S NAME (Type) <u>H. W. SCHEYE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandycrest Cemetery, Rural, Westminster Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>			ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3/4/56</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Harry</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03654	
Medical Examiner										Reg. Dist. No. 40	
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
a. COUNTY <b>Baltimore</b> <b>2545</b> <b>MARYLAND</b>					a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
X <b>Franklinville</b>					<b>35 yrs.,</b>		<b>Franklinville</b> X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED										4. DATE OF DEATH	
First <b>Alice</b> Middle <b>B.</b> Last <b>Carroll</b>										Month <b>March</b> Day <b>30</b> Year <b>1955</b>	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>female</b>		<b>white</b>				<b>Jan. 19, 1870</b>		<b>86</b>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<b>Practical Nurse</b>				<b>Self Employed</b>		<b>Harford Co., Maryland</b>			<b>U.S.A.</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
<b>James Carroll</b>					<b>Anna E. Galloway</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address						
<b>no</b>			<b>none</b>		<b>Clifton M. Dowling, Bel Air, Maryland.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Thrombosis</b>										<b>Evening</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Severe Secondary Anemia</b>										<b>undet</b>	
(c) <b>Generalized Arteriosclerosis</b>										<b>undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>examined</b> <b>19</b> <b>after death</b> , 19 <b>after death</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:30 p. M.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>John C. Hyle</b>					M.D. <b>Deputy Medical Examiner</b> <b>4-2-56</b>						
PHYSICIAN'S NAME (Type) <b>J.C. Hyle</b>					<b>7527 Bel Air Rd., Balto., 6 Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>			<b>Apr. 3, 1956</b>		<b>Franklin Presbyterian</b>			<b>Franklinville, Balto., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
<b>Howard K. McCombs &amp; Son</b>					<b>Abingdon Md.</b>		<b>4-3-56</b>		<b>Wm. M. Mott</b>		

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

MINISTERS OF HEALTH - BATHING

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>RESIDENCE</p>		<p>DATE OF BIRTH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF BURIAL</p>		<p>PLACE OF BURIAL</p>	
<p>NAME OF MINISTER</p>		<p>NAME OF REGISTRAR</p>	
<p>SIGNATURE OF MINISTER</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician and cemetery have been signed by the attending physician and cemetery, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 2546 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

02532

33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hanover Road</b>		d. STREET ADDRESS <b>Hanover Road</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>D.</b> Last <b>Cartzendafner</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1892</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua Cartzendafner</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ogle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-10-6015</b>	
17. INFORMANT Address <b>Mrs. Lola D. Cartzendafner, Upperco, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 wks</b> <b>10 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August</b> , 1948, to <b>March 23</b> , 1956, that I last saw the deceased alive on <b>March 22</b> , 1956, and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>48 Main St., Reisterstown, Md. 3/23/56</b>			
ACTUAL SIGNATURE <b>Martin E. Strobel</b>		PHYSICIAN'S NAME (Type) <b>Martin E. Strobel</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 25, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		24. REC'D BY REGISTRAR DATE <b>3-23-56</b>	
ADDRESS <b>Reisterstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	
25d. LOCATION (City, town, or county) (State) <b>Carroll County, Md.</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2547 CERTIFICATE OF DEATH

02533

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grays</b>				c. LENGTH OF STAY IN 1b <b>Grays</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>				d. STREET ADDRESS <b>River Road</b>			
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>A.</b> Last <b>CAVEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6, 1882</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Gainesville, Va.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John H. Ellis</b>				14. MOTHER'S MAIDEN NAME <b>Annie Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>George C. Cavey, Ellicott City, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-7</b> , 19 <b>48</b> to <b>3/21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/21</b> , 19 <b>56</b> , and that death occurred at <b>11:59</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b> DATE SIGNED <b>3/30/56</b> ACTUAL SIGNATURE <b>George E. Burgtorf</b> M.D. PHYSICIAN'S NAME (Type) <b>George E. Burgtorf M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3/31/56</b>			
24b. REGISTRAR'S SIGNATURE <b>J.E. Harry</b>							

BUREAU V. S.

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2548

## CERTIFICATE OF DEATH

02534

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>10 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3601 Fait Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>PETER</b> Last <b>CELMER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 18, 1929</b>		9. AGE (In years last birthday) <b>26</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER'S HELPER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>STANDARD OIL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JESS W. CELMER</b>				14. MOTHER'S MAIDEN NAME <b>HELEN DEKOWSKI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>YES</b> (If yes, give war or dates of service) <b>PL 28</b>		16. SOCIAL SECURITY NO. <b>214-26-9250</b>		17. INFORMANT <b>CLIN.REC., VET.ADM.HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> <b>430.0</b> DUE TO <b>SUBACUTE BACTERIAL ENDOCARDITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>3 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>MARCH 7, 1956</b> to <b>MARCH 17, 1956</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3-18-56</b> ACTUAL SIGNATURE <b>William M. Lavette M.D.</b> PHYSICIAN'S NAME (Type) <b>William M. Lavette, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR 20 '56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART OF JESUS CEM, BALTIMORE COUNTY, MARYLAND</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>				24. REC'D BY REGISTRAR <b>March 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lister</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF SHERIFF [Faint text]	
SIGNATURE OF TOWNSHIP CLERK [Faint text]		SIGNATURE OF COUNTY CLERK [Faint text]		SIGNATURE OF STATE CLERK [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF SHERIFF [Faint text]	
SIGNATURE OF TOWNSHIP CLERK [Faint text]		SIGNATURE OF COUNTY CLERK [Faint text]		SIGNATURE OF STATE CLERK [Faint text]	

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2549

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> <u>28</u>				c. LENGTH OF STAY IN 1b <u>1yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Hood Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Bell</u> Last <u>Christie</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 21, 1877</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Christie</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Clay Ware</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Balto., 29, Md.</u> <u>Mrs. G. Russell Thomas, niece, 4204 Leeds Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe Coronary Insufficiency</u> DUE TO (c) <u>Marked Atherosclerosis C-V-D</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>53</u> , to <u>3/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>56</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor F. King</u>				ADDRESS (Street, city or town, state) <u>715 Federal Rd</u>			
DATE SIGNED <u>3/11/56</u>				M.D. <u>715 Federal Rd</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Victor F. King</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Russell Thomas, 4204 Leeds Avenue, Balto., 29, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page One of Two

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. DATE OF DEATH                  _____</p>		<p>5. TIME OF DEATH                  _____</p>		<p>6. PLACE OF DEATH                  _____</p>	
<p>7. CAUSE OF DEATH                  _____</p>		<p>8. MANNER OF DEATH                  _____</p>		<p>9. PLACE OF BIRTH                  _____</p>	
<p>10. OCCUPATION                  _____</p>		<p>11. EDUCATION                  _____</p>		<p>12. MARITAL STATUS                  _____</p>	
<p>13. PREVIOUS ILLNESS                  _____</p>		<p>14. PREVIOUS SURGERY                  _____</p>		<p>15. PREVIOUS TRAUMA                  _____</p>	
<p>16. PREVIOUS DRUGS                  _____</p>		<p>17. PREVIOUS ALCOHOL                  _____</p>		<p>18. PREVIOUS TOBACCO                  _____</p>	
<p>19. PREVIOUS RADIATION                  _____</p>		<p>20. PREVIOUS CHEMOTHERAPY                  _____</p>		<p>21. PREVIOUS HORMONE THERAPY                  _____</p>	
<p>22. PREVIOUS TRANSFUSION                  _____</p>		<p>23. PREVIOUS ORGANS                  _____</p>		<p>24. PREVIOUS TISSUES                  _____</p>	
<p>25. PREVIOUS DONOR                  _____</p>		<p>26. PREVIOUS RECIPIENT                  _____</p>		<p>27. PREVIOUS TRANSPLANT                  _____</p>	
<p>28. PREVIOUS TRANSFUSION                  _____</p>		<p>29. PREVIOUS ORGANS                  _____</p>		<p>30. PREVIOUS TISSUES                  _____</p>	
<p>31. PREVIOUS DONOR                  _____</p>		<p>32. PREVIOUS RECIPIENT                  _____</p>		<p>33. PREVIOUS TRANSPLANT                  _____</p>	
<p>34. PREVIOUS TRANSFUSION                  _____</p>		<p>35. PREVIOUS ORGANS                  _____</p>		<p>36. PREVIOUS TISSUES                  _____</p>	
<p>37. PREVIOUS DONOR                  _____</p>		<p>38. PREVIOUS RECIPIENT                  _____</p>		<p>39. PREVIOUS TRANSPLANT                  _____</p>	
<p>40. PREVIOUS TRANSFUSION                  _____</p>		<p>41. PREVIOUS ORGANS                  _____</p>		<p>42. PREVIOUS TISSUES                  _____</p>	
<p>43. PREVIOUS DONOR                  _____</p>		<p>44. PREVIOUS RECIPIENT                  _____</p>		<p>45. PREVIOUS TRANSPLANT                  _____</p>	
<p>46. PREVIOUS TRANSFUSION                  _____</p>		<p>47. PREVIOUS ORGANS                  _____</p>		<p>48. PREVIOUS TISSUES                  _____</p>	
<p>49. PREVIOUS DONOR                  _____</p>		<p>50. PREVIOUS RECIPIENT                  _____</p>		<p>51. PREVIOUS TRANSPLANT                  _____</p>	
<p>52. PREVIOUS TRANSFUSION                  _____</p>		<p>53. PREVIOUS ORGANS                  _____</p>		<p>54. PREVIOUS TISSUES                  _____</p>	
<p>55. PREVIOUS DONOR                  _____</p>		<p>56. PREVIOUS RECIPIENT                  _____</p>		<p>57. PREVIOUS TRANSPLANT                  _____</p>	
<p>58. PREVIOUS TRANSFUSION                  _____</p>		<p>59. PREVIOUS ORGANS                  _____</p>		<p>60. PREVIOUS TISSUES                  _____</p>	
<p>61. PREVIOUS DONOR                  _____</p>		<p>62. PREVIOUS RECIPIENT                  _____</p>		<p>63. PREVIOUS TRANSPLANT                  _____</p>	
<p>64. PREVIOUS TRANSFUSION                  _____</p>		<p>65. PREVIOUS ORGANS                  _____</p>		<p>66. PREVIOUS TISSUES                  _____</p>	
<p>67. PREVIOUS DONOR                  _____</p>		<p>68. PREVIOUS RECIPIENT                  _____</p>		<p>69. PREVIOUS TRANSPLANT                  _____</p>	
<p>70. PREVIOUS TRANSFUSION                  _____</p>		<p>71. PREVIOUS ORGANS                  _____</p>		<p>72. PREVIOUS TISSUES                  _____</p>	
<p>73. PREVIOUS DONOR                  _____</p>		<p>74. PREVIOUS RECIPIENT                  _____</p>		<p>75. PREVIOUS TRANSPLANT                  _____</p>	
<p>76. PREVIOUS TRANSFUSION                  _____</p>		<p>77. PREVIOUS ORGANS                  _____</p>		<p>78. PREVIOUS TISSUES                  _____</p>	
<p>79. PREVIOUS DONOR                  _____</p>		<p>80. PREVIOUS RECIPIENT                  _____</p>		<p>81. PREVIOUS TRANSPLANT                  _____</p>	
<p>82. PREVIOUS TRANSFUSION                  _____</p>		<p>83. PREVIOUS ORGANS                  _____</p>		<p>84. PREVIOUS TISSUES                  _____</p>	
<p>85. PREVIOUS DONOR                  _____</p>		<p>86. PREVIOUS RECIPIENT                  _____</p>		<p>87. PREVIOUS TRANSPLANT                  _____</p>	
<p>88. PREVIOUS TRANSFUSION                  _____</p>		<p>89. PREVIOUS ORGANS                  _____</p>		<p>90. PREVIOUS TISSUES                  _____</p>	
<p>91. PREVIOUS DONOR                  _____</p>		<p>92. PREVIOUS RECIPIENT                  _____</p>		<p>93. PREVIOUS TRANSPLANT                  _____</p>	
<p>94. PREVIOUS TRANSFUSION                  _____</p>		<p>95. PREVIOUS ORGANS                  _____</p>		<p>96. PREVIOUS TISSUES                  _____</p>	
<p>97. PREVIOUS DONOR                  _____</p>		<p>98. PREVIOUS RECIPIENT                  _____</p>		<p>99. PREVIOUS TRANSPLANT                  _____</p>	
<p>100. PREVIOUS TRANSFUSION                  _____</p>		<p>101. PREVIOUS ORGANS                  _____</p>		<p>102. PREVIOUS TISSUES                  _____</p>	

BUREAU V. B.

MAR 14 1956

RECEIVED

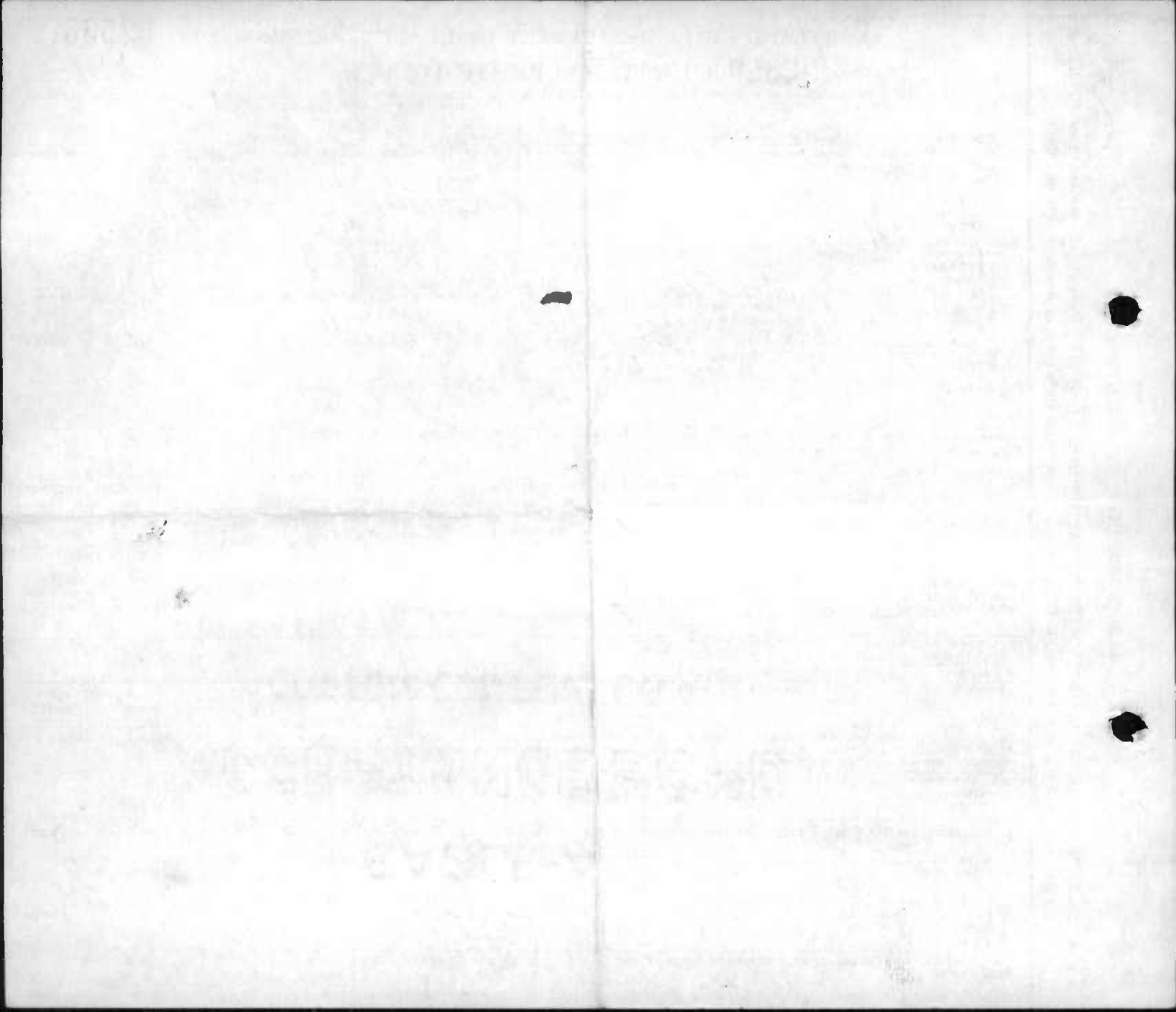


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02536  
 2550 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Home</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Box 355A Route 10</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>Todds Farm Sp. Pt.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Oliver A. Clatterbuck</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>3 - 6 19 56</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Aug. 5 - 1899</i>
9. AGE last birthday <i>56 11/11</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Todds Farm</i>	11. BIRTHPLACE (State or foreign country): <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Louis Clatterbuck</i>	
14. MOTHER'S MAIDEN NAME: <i>Matilda Mills</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Effie Clatterbuck (Wife) Above</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Massive hemoptysis</i>			<i>30 min.</i>
ANTECEDENT CAUSE (S) DUE TO <i>Far Advanced Pulmonary Tuberculosis</i>			<i>4 years at least</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 15, 1955</i> , to <i>March 6, 1956</i> , that I last saw the deceased alive on <i>Feb. 15, 1956</i> , and that death occurred at <i>9:05 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>David Cuervo</i>		DATE SIGNED <i>3/6/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-9-56</i>	NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Em.</i>
LOCATION (City, town, or county) (State) <i>Eastern Blvd. Essex</i>		24. FUNERAL DIRECTOR ADDRESS <i>John B. Donnelly Essex</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3/6/56</i>		REGISTRAR'S SIGNATURE <i>H. H. [Signature]</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2551 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02537

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>52</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Timothy Lane</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>St. Timothy Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>COMET</u> Last <u>COATES</u>		<b>4. DATE OF DEATH</b> Month <u>1956</u> Day <u>March</u> Year <u>21, 1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 13, 1874</u>
<b>9. AGE</b> (In years, last birthday) <u>81</u>	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>foreman-transportation</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>G&amp;E Co</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md</u>
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>Retired</u>		<b>13. FATHER'S NAME</b> <u>Wm. A. Coates</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Forsyth</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mrs. Lillie E. Coates</u> Address <u>St. Timothy Lane</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. m.</u> <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>Geo. S.M. Kieffer</u>		<b>DATE SIGNED</b> <u>March 21, 1956</u>	
<b>EXAMINER'S NAME</b> (Type) <u>Geo. S.M. Kieffer</u>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>3/24/56</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge Cem.</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Pikesville, Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Lickner</u>		<b>24. REC'D BY REGISTRAR</b> <u>March 23, 1956</u>	
<b>25. ADDRESS</b> <u>17. Md.</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>V. E. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		TIME		FINGERPRINT	
SIGNATURE OF WITNESS		TITLE		DATE		PLACE		TIME		FINGERPRINT	
SIGNATURE OF JURY		TITLE		DATE		PLACE		TIME		FINGERPRINT	
SIGNATURE OF JUDGE		TITLE		DATE		PLACE		TIME		FINGERPRINT	

BUREAU V. S.

MAR 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02538				
2552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										38				
Item 7 FilmG194 3-22-56 et										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co.</u>					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>186 Dumbarton Road</u>										d. STREET ADDRESS <u>186 Dumbarton Rd.</u>				
3. NAME OF DECEASED (Type or print) First <u>DOROTHY</u> Middle <u>IRENE</u> Last <u>COMEAX</u>										4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1956</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1917</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Stores</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Harry W. Beck</u>						14. MOTHER'S MAIDEN NAME <u>Bess Bachtell</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-10-3109</u>		17. INFORMANT Address <u>Mr. M.J.Comeaux-186 Dumbarton Rd.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to chronic nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>592x</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE <u>R. S. Fisher</u>						M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/14/56</u>				
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Pk. Cem. Balto. Co.</u>				22d. LOCATION (City, town, or county) (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <u>WIEDEFELD &amp; SON</u>						ADDRESS <u>GREENMOUNT AVE &amp; 22ND</u>				24a. REC'D BY REGISTRAR <u>Model</u>		24b. REGISTRAR'S SIGNATURE <u>Grays</u>		

MAR 19 1956

MASSACHUSETTS DEPARTMENT OF HEALTH-BELLEVILLE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 18 1956

RECEIVED



02539

MARYLAND

STATE DEPARTMENT OF HEALTH

2553

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>	
TOWN <u>College Manor</u>		TOWN <u>Chestnut Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>GEORGE W CONWAY</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>7-26-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd. Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tel. Co.</u>	9. AGE last birthday <u>88</u> yrs.
13. FATHER'S NAME <u>William P. Conway</u>		11. BIRTHPLACE (State or foreign country) <u>Lynn, Mass.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY NO. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rich</u>	
		17. INFORMANT AND ADDRESS <u>Mr. Clinton Conway-Chestnut Hill, /</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs. plus 3 das.</u>
9047 Immediate cause (a) <u>Cardiac failure due to cor pulmonale</u>		
Antecedent cause(s) (b) <u>Emphysema, chronic bronchitis, bronchiectasis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>fall occurred in his room 4:00 a.m. 3/27/56</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1950 to March 1956, that I last saw the deceased alive on March 28, 1956, and that death occurred at 9:10 a.m., from the causes and on the date stated above.

SIGNATURE Richard H. Tillman MD ADDRESS 3035 St. Paul St DATE SIGNED March 29, 1956

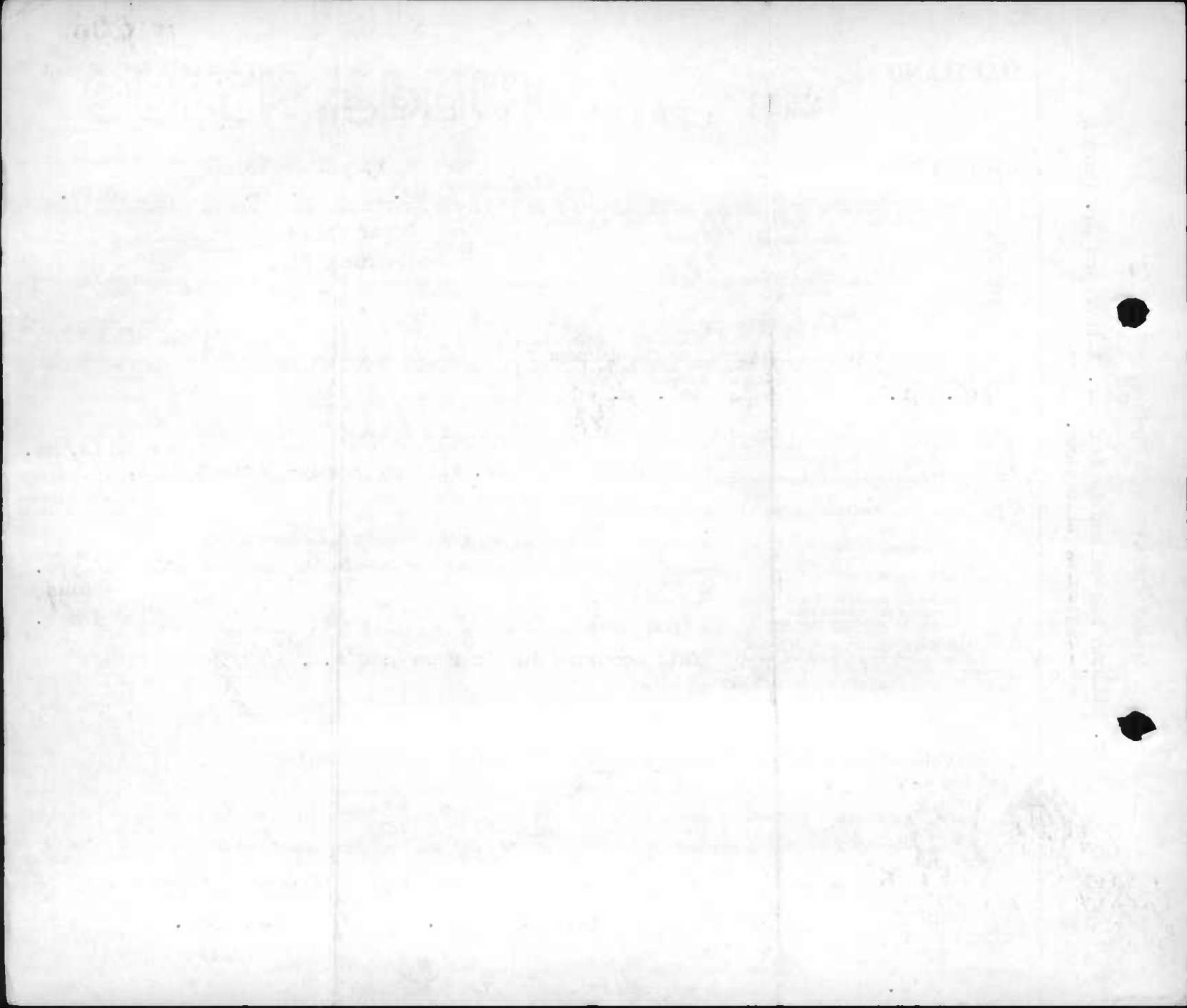
23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 3/31/56 NAME OF CEMETERY OR CREMATORY Pine Grove Cem. LOCATION (City, town, or county) (State) Lynn, Mass.

DATE REC'D BY LOCAL REG. 3-27-56 REGISTRAR'S SIGNATURE John J. Loken & Sons - Balto ADDRESS 17 Md.

Ok'd. by: Rollin C. Hudson, M.D. SPC/BPB

MARGIN RESERVED FOR BINDING

Dr. Tillman has talked to both Dr. Fisher and Dr. Hudson regarding this case.



02540

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2554

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTO - Co. Md</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>52</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE - BALTIMORE COUNTY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5939 JOHNNYCAKE Rd</u>		STREET ADDRESS <u>5939 JOHNNYCAKE Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>A</u> (Middle) <u>COOPER</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-17-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKERY BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKER</u>	9. AGE last birthday <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>COOPER</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>196-01-3008</u>	
17. INFORMANT AND ADDRESS <u>MRS. SUE GRUENINGER - 5939 JOHNNYCAKE Rd</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Embolism

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocarditis(c) Cerebral Vascular

## INTERVAL BETWEEN ONSET AND DEATH

16 hrs11 hrs11 hrs

## II. OTHER SIGNIFICANT CONDITIONS

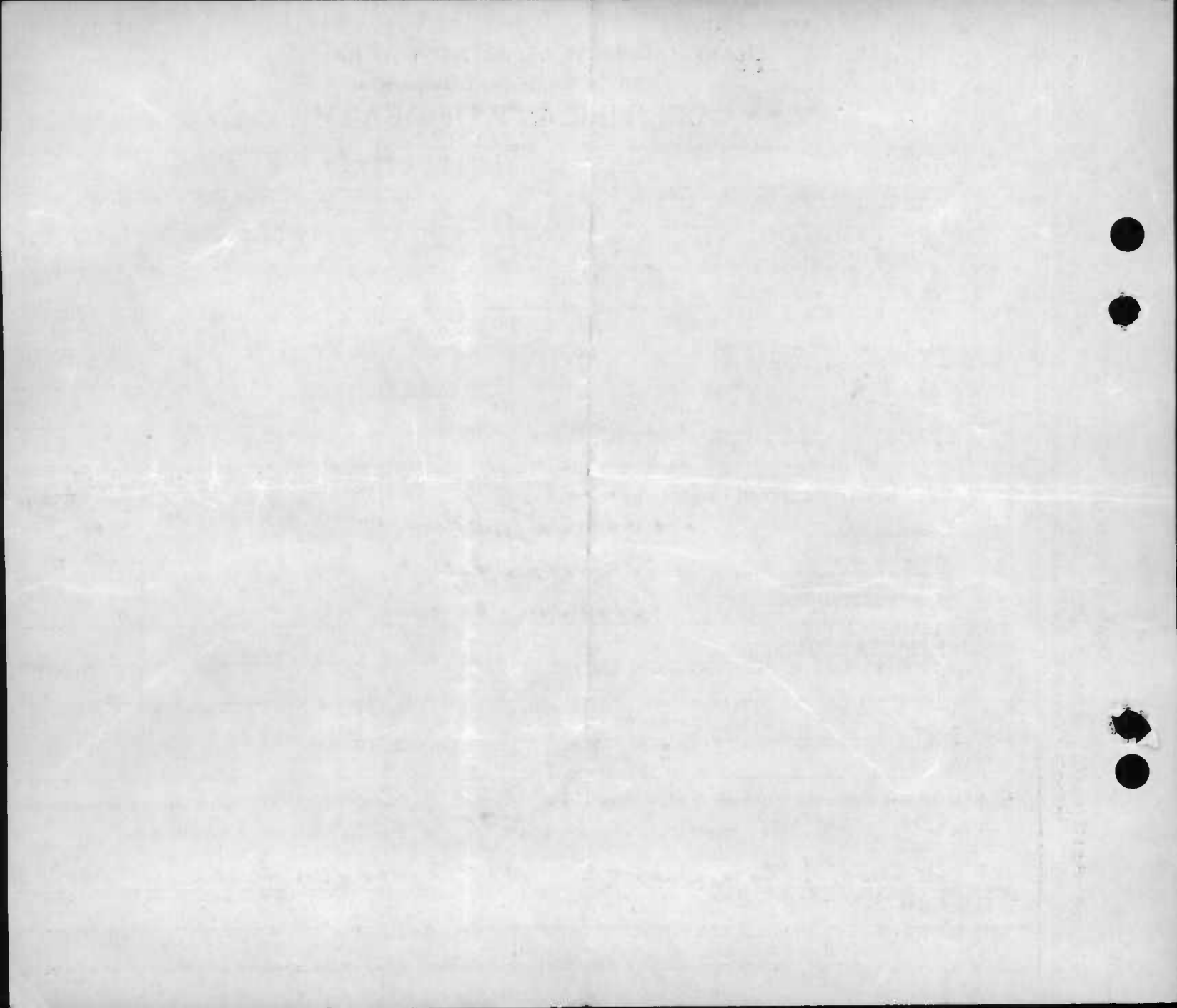
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr 10, 1956</u> , to <u>Mar 19, 1956</u> , that I last saw the deceased alive on <u>Mar 14, 1956</u> , and that death occurred at <u>7:20</u> m., from the causes and on the date stated above.					
SIGNATURE <u>James V. Gruninger</u>		ADDRESS <u>4173 Frederick Ave</u>		DATE SIGNED <u>3/19/56</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Agnes Funeral Home</u>	
LOCATION (City, town, or county) (State) <u>SCRANTON - PENNA</u>		24. FUNERAL DIRECTOR <u>THOMAS J. KENNY INC</u>		ADDRESS <u>1600 Hollins St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2555 CERTIFICATE OF DEATH

02541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>				c. LENGTH OF STAY IN b. <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 Armacost Nursing Home</b>				d. STREET ADDRESS <b>Franklinville Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>B.</b> Last <b>Crossmore</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>June 18, 1870</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joshua Hammond</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Ledley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frank R. Hammond-Franklinville Rd. Upper Falls</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Decompensation</b> DUE TO (b) <b>Bronchial Pneumonia</b> DUE TO (c) <b>Generalized Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>7 days</b> <b>15 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 7</b> , 19 <b>50</b> , to <b>March 20</b> , 19 <b>56</b> that I last saw the deceased alive on <b>March 20</b> , 19 <b>56</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. O'Donnell M.D. 2501 York Rd. Towson #42nd 3/24/56</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>				PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanahan Funeral Home - 7401 Belair Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>27 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Markel Gray</b>	

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1936

RECEIVED

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. PLACE OF BIRTH [Faint text]	
10. OCCUPATION [Faint text]		11. EDUCATION [Faint text]		12. COLOR [Faint text]	
13. MARITAL STATUS [Faint text]		14. RELIGION [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. SIGNATURE OF WITNESS [Faint text]		17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF DECEASED [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF DECEASED [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]		33. SIGNATURE OF DECEASED [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]		39. SIGNATURE OF DECEASED [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]		45. SIGNATURE OF DECEASED [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]		51. SIGNATURE OF DECEASED [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF DECEASED [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]		63. SIGNATURE OF DECEASED [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]		69. SIGNATURE OF DECEASED [Faint text]	
70. SIGNATURE OF DECEASED [Faint text]		71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]		75. SIGNATURE OF DECEASED [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]		81. SIGNATURE OF DECEASED [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF DECEASED [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]		93. SIGNATURE OF DECEASED [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]		99. SIGNATURE OF DECEASED [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF DECEASED [Faint text]		102. SIGNATURE OF DECEASED [Faint text]	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BUREAU OF VITAL STATISTICS, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, WASHINGTON, D.C.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02542

## 2556 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>English Consul</u>	
TOWN <u>Catonsville</u>				STREET ADDRESS (If rural give location)		/	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS <u>3608 Annapolis Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>WILLIAM</u> (Middle) <u>S.</u> (Last) <u>DIXON</u>				(Month) <u>Mar.</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 12, 1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Dixon</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-6585</u>		17. INFORMANT & ADDRESS <u>Mr. James A. Dixon-Towson J., Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
163X IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arteriosclerotic Heart Disease</u>				<u>5 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>July 2, 1955</u> , to <u>March 17, 1956</u> , that I last saw the deceased alive on <u>March 17, 1956</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Regan Sudam</u>				DATE SIGNED <u>3/17/56</u>			
ADDRESS (Street, city, town, state) <u>5010A Ritchie Hwy. Balto., Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR <u>March 19, 1956</u>		REGISTRAR'S SIGNATURE <u>F. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner &amp; Sons - Balto.</u>		ADDRESS <u>Md.</u>	

# DEATH CERTIFICATE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. DATE

13. PLACE OF DEATH

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

BUREAU V. A.

APR 20 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02543  
37

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Cockeysville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Darden</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>23</u> Year <u>1956</u>															
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-25-92</u>		<b>9. AGE</b> (In years last birthday) <u>63</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FARM</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.C.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>							
<b>13. FATHER'S NAME</b> <u>SAMUEL</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZ. M. GIBSON</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Family - Same</u>				<b>Address</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific Aortic Stenosis</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> <b>Noturol causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>Sydney L. Katz</u> <b>M.D.</b>												<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b>												<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)				<b>22b. DATE THEREOF</b> <u>3/27/56</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>WALKER CHAPEL</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>DARDEN, N.C.</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>McCully</u>						<b>ADDRESS</b> <u>FUNERAL HOMES</u>						<b>24a. REC'D BY REGISTRAR</b> <u>MAR 27 1956</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Anne Mac Rary</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 \$25 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER		OFFICE		COUNTY		STATE			
JAMES M. JONES		M		35		1923		BALTIMORE		W		CATHOLIC		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOME		1956		10:00 AM		J. M. JONES		BALTIMORE		MD					
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S TIME OF DEATH		MOTHER'S TIME OF DEATH		FATHER'S SIGNATURE		MOTHER'S SIGNATURE	
JAMES M. JONES		JANE M. JONES		LABORER		LABORER		1910		1915		1940		1945		HEART DISEASE		HEART DISEASE		NATURAL		NATURAL		HOME		HOME		1940		1945		10:00 AM		10:00 AM		J. M. JONES		J. M. JONES	
GRANDFATHER'S NAME		GRANDMOTHER'S NAME		GRANDFATHER'S OCCUPATION		GRANDMOTHER'S OCCUPATION		GRANDFATHER'S BIRTH		GRANDMOTHER'S BIRTH		GRANDFATHER'S DEATH		GRANDMOTHER'S DEATH		GRANDFATHER'S CAUSE OF DEATH		GRANDMOTHER'S CAUSE OF DEATH		GRANDFATHER'S MANNER OF DEATH		GRANDMOTHER'S MANNER OF DEATH		GRANDFATHER'S PLACE OF DEATH		GRANDMOTHER'S PLACE OF DEATH		GRANDFATHER'S DATE OF DEATH		GRANDMOTHER'S DATE OF DEATH		GRANDFATHER'S TIME OF DEATH		GRANDMOTHER'S TIME OF DEATH		GRANDFATHER'S SIGNATURE		GRANDMOTHER'S SIGNATURE	
JAMES M. JONES		JANE M. JONES		LABORER		LABORER		1900		1905		1930		1935		HEART DISEASE		HEART DISEASE		NATURAL		NATURAL		HOME		HOME		1930		1935		10:00 AM		10:00 AM		J. M. JONES		J. M. JONES	

RECEIVED  
 MAR 27 1956  
 BUREAU V. S.

## 2558 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ROSEDALE		LENGTH OF STAY (In this place) 10 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN ROSEDALE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1617 ROSEDALE HEIGHTS AVE.				STREET ADDRESS (If rural give location) 1617 ROSEDALE HEIGHTS AVE.			
3. NAME OF DECEASED (Type or Print) FRANK NICKOLAS DORN				4. DATE OF DEATH (Month) (Day) (Year) MARCH 19, 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JULY 5, 1890	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if changed) STATION MANAGER		10b. KIND OF BUSINESS OR INDUSTRY AMERICAN OIL CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE DORN				14. MOTHER'S MAIDEN NAME BARBARA KEMMIT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 215 03 8708		17. INFORMANT & ADDRESS MRS MINNA DORN		SAME.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Coronary occlusion Carcinoma of Lung			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs			
19a. DATE OF OPERATION 1955		19b. MAJOR FINDINGS OF OPERATION Carcinoma rt. Lung		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 1, 1956, to March 19, 1956, that I last saw the deceased alive on March 18, 1956, and that death occurred at 11 AM, from the causes and on the date stated above.							
SIGNATURE W. Baumgardner M.D.				ADDRESS (Street, city, town, state) Baltimore Md		DATE SIGNED 3/19/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE HEREOF 3/22/56		NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY WOODLAWN MARYLAND.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR March 22, 1956		REGISTRAR'S SIGNATURE Mrs. Edith Surley		25. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. ADDRESS BALTIMORE MARYLAND. Sander			

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



5258 CERTIFICATE OF DEATH

MAR 1956 STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Page One

1. Usual Residence and Where Deceased

MARYLAND

CITY OF BALTIMORE

WARD 1

STREET

APARTMENT

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

DEFINITE

UNCERTAIN

UNKNOWN

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

DATE OF DEATH

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

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DATE OF DEATH

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

DATE OF DEATH

Government of Maryland  
Governor

Secretary

Government of Maryland

1956

BUREAU V. S.

MAR 22 1956

RECEIVED  
March 22 1956  
Baltimore  
M. J. Cunningham  
March 22



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 18 & 21 Film G195 4-6-56 <sup>ams</sup>

MARYLAND STATE DEPARTMENT OF HEALTH

02545

2559

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Towson</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>328 Dixie Drive</u>		STREET ADDRESS (If rural, give location) <u>328 Dixie Drive</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>P.</u> (Last) <u>Dunn</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>26</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 16, 1882</u>
9. AGE last birthday <u>74</u> yrs.		10. If under 1 year: Months <u>7</u> Days <u>4</u> Hours <u>19</u> Mins. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. file Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph B. Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Jas. P. Dunn 328 Dixie Drive</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
903.8 Immediate cause (a) <u>Septicemic Pneumonia</u>	(b) <u>Generalized Arteriosclerosis</u>	<u>2 weeks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Fractured Hip</u>		<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>9 months</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Injury Cape May, N.J.</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>N.J.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug</u> <u>1955</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell on front porch</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

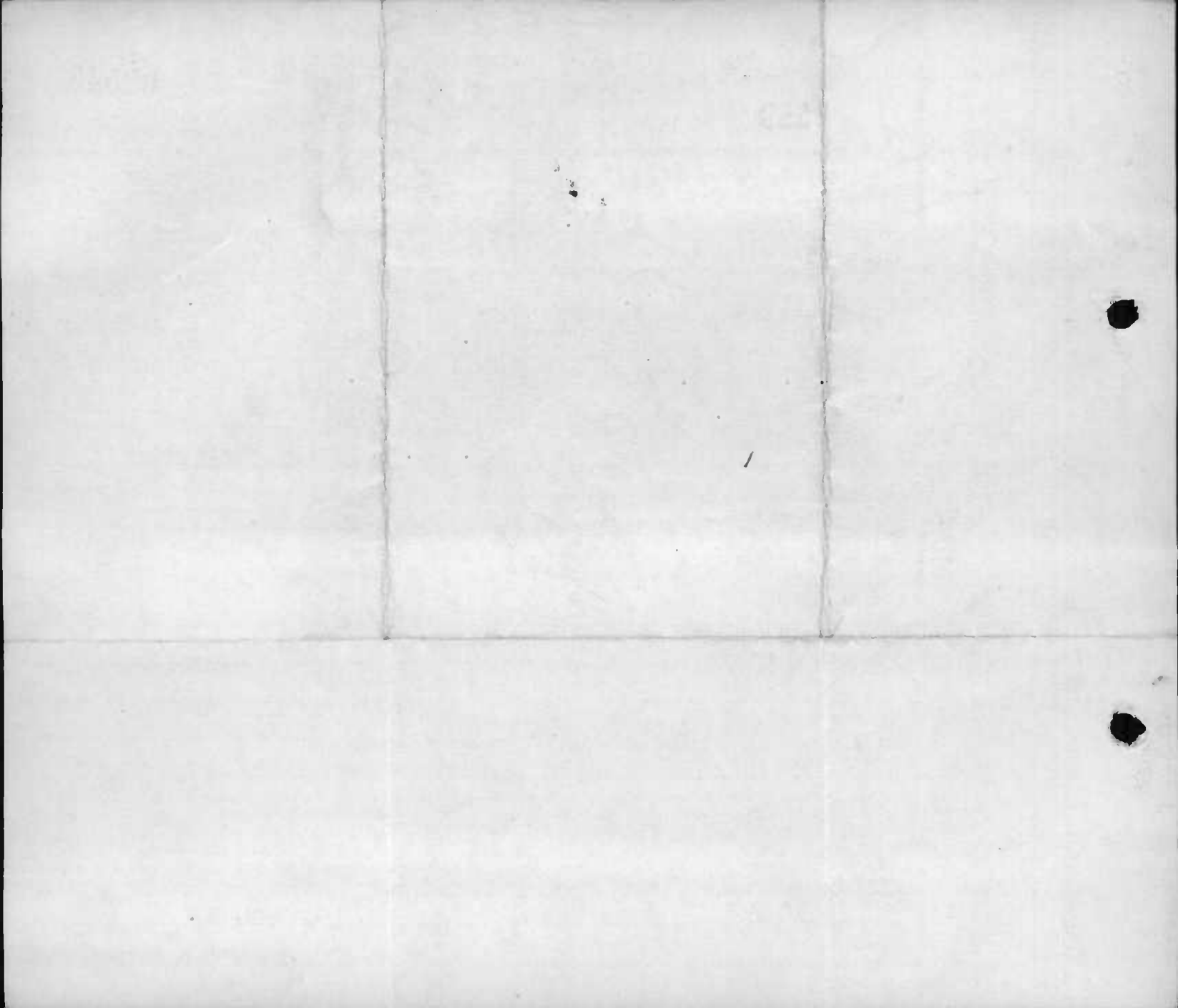
SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/28/56</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>3-27-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>W. W. Meeks &amp; Son</u>	ADDRESS <u>805 N. Calvert St.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02546

2560

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7606 Queen Anne Drive</b>				d. STREET ADDRESS <b>7809 Oakdale Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Rev. Henry</b> Middle <b>W.</b> Last <b>Ellenberger</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 24, 1873</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Conrad Ellenberger</b>				14. MOTHER'S MAIDEN NAME <b>112 Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>H. Leonard Ellenberger-7606 Queen Anne Drive</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Per</b> , 19 <b>53</b> , to <b>March 3, 1956</b> , that I last saw the deceased alive on <b>March 3</b> , 19 <b>56</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Louis Krause</b> M.D. <b>11/6 Chase St.</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-6-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Stemmers Run, Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. L. Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. R. M. Bacon</b>							

3731

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2500

<p>1. Name of deceased: <u>John A. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1880</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>Mar 10, 1936</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Usual place of abode: <u>Home</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Jones</u></p>		<p>12. Name of funeral home: <u>None</u></p>	
<p>13. Name of informant: <u>John A. Smith</u></p>		<p>14. Address of informant: <u>123 Main St.</u></p>	
<p>15. Signature of informant: <u>[Signature]</u></p>		<p>16. Signature of physician: <u>[Signature]</u></p>	

BUREAU V. 3.

MAR 6 1936

RECEIVED

RECEIVED  
MAR 10 1936  
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02547

2551

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				d. STREET ADDRESS <u>4001 Glenmore Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>England</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1880</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railway Mail Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland.</u>	
13. FATHER'S NAME <u>John H. England</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William J. England-4335 Berger Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V disease</u> DUE TO (c) <u>Pyelo-nephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/12</u> , 19 <u>56</u> , to <u>3/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>507</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tor H. Sedlack</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/16/56</u>			
PHYSICIAN'S NAME (Type) <u>Towson, J. Fred.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Losecker Funeral Home - 7401 Belair Rd.</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

RECEIVED



Items 8 & 9-Film G194  
3/29/56 dmr.

02548

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2514 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>DUNDALK</u> COUNTY <u>MD.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
TOWN <u>DUNDALK</u>		TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3527 DUNHAVEN</u>		STREET ADDRESS (If rural, give location) <u>3527 DUNHAVEN RD</u>	
3. NAME OF DECEASED (Type or Print) <u>SOPHIA</u> (First) <u>FEDORCZYK</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>HOUSEWIFE</u>	8. DATE OF BIRTH <u>11/14/1879</u>
9. AGE last birthday <u>81</u> yrs.		10. AGE last birthday <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>S</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA CHMIEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>NO</u>	
17. INFORMANT AND ADDRESS <u>STELLA VOYAK. 3527 DUNHAVEN RD</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>	<u>1 day</u>
Antecedent cause(s) (b) <u>Hypertension cardio-vascular disease</u>	<u>3-4 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-12, 1956, to 3-19, 1956, that I last saw the deceased alive on 3-19, 1956, and that death occurred at 7:11 m., from the causes and on the date stated above.

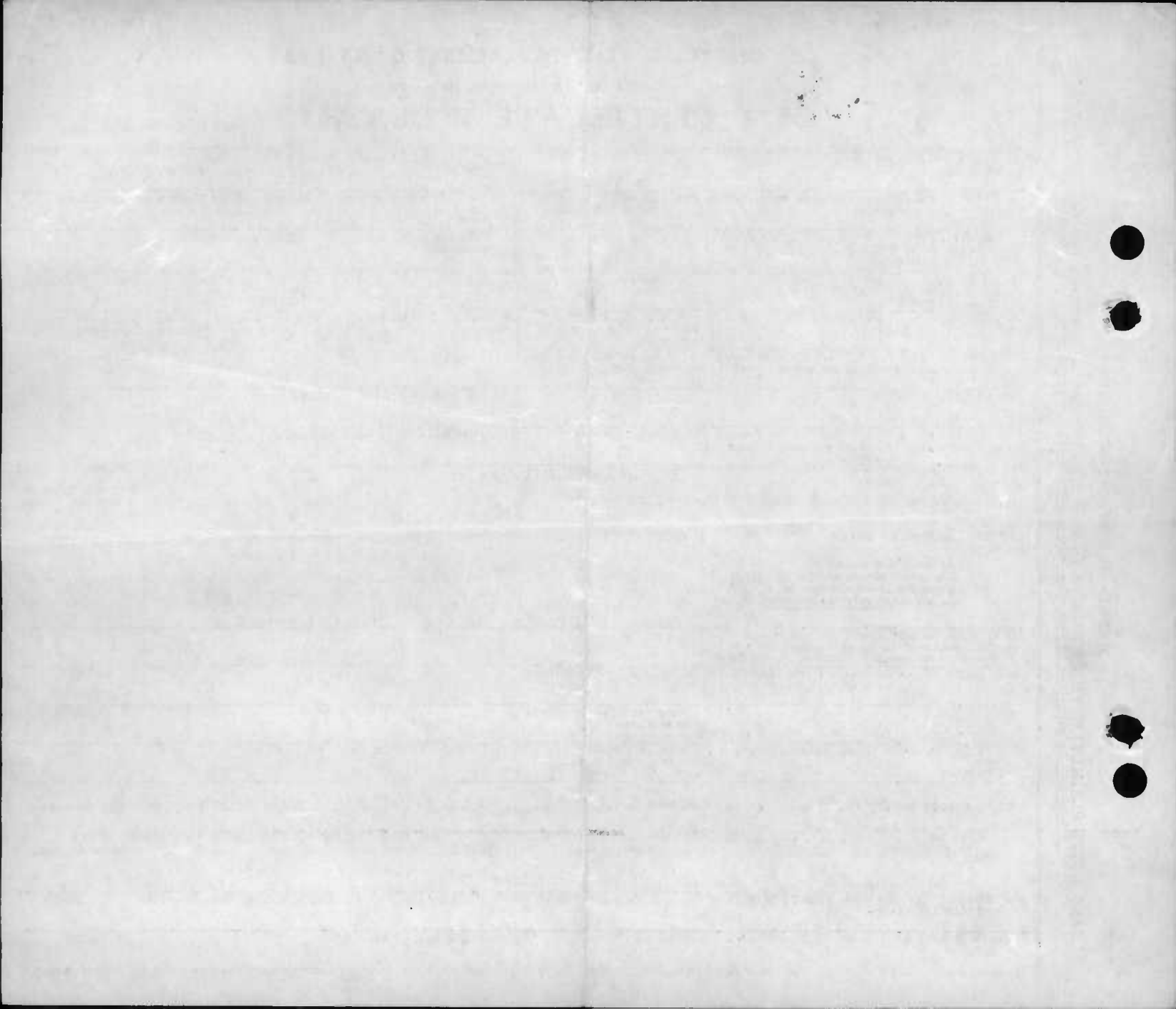
SIGNATURE Eugene F. Nevey MD ADDRESS 7001 Mornington Rd Dundalk Md DATE SIGNED 3-20-56

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>WYOMING CEMETERY</u>	<u>3-20-56</u>	<u>WYOMING CEMETERY</u>	<u>WILKES BARRE PA</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-20-56</u>	<u>A. W. Hedrick</u>	<u>Walter Dabowski</u>	<u>10014 Dundalk Ave Baltimore Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02549

2515

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>26 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2909 DUNDALK AVE</u>				STREET ADDRESS (If rural give location) <u>2909 DUNDALK AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE EARL FENNELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 14, 1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 29, 1889</u>	9. AGE (last birthday) yrs. <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURN FORMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ANTHONY FENNELL</u>				14. MOTHER'S MAIDEN NAME <u>KILLIE FLEMING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-07-0178</u>		17. INFORMANT & ADDRESS <u>VIOLA D. FENNELL - SAME ADDRESS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular</u>				INTERVAL BETWEEN ONSET AND DEATH <u>340</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 1955</u> to <u>March 14, 1956</u> , that I last saw the deceased alive on <u>March 14, 1956</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. S. Davis</u>				ADDRESS (Street, city, town, state) <u>Dundalk, Md.</u> DATE SIGNED <u>3/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>		LOCATION (City, town, or county) (State) <u>HOWARD Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 16 1956</u>		REGISTRAR'S SIGNATURE <u>Damon L. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Bradley</u>		ADDRESS <u>Dundalk, Md.</u>	

# CERTIFICATE OF DEATH

Form 100-10-1

1. Name of deceased (Print or write full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial society

19. Signature of religious society

20. Signature of other

21. Signature of other

22. Signature of other

23. Signature of other

24. Signature of other

25. Signature of other

26. Signature of other

27. Signature of other

28. Signature of other

29. Signature of other

30. Signature of other

31. Signature of other

32. Signature of other

33. Signature of other

34. Signature of other

35. Signature of other

36. Signature of other

37. Signature of other

38. Signature of other

39. Signature of other

40. Signature of other

41. Signature of other

42. Signature of other

43. Signature of other

BUREAU V. S.

MAR 16 1956

RECEIVED

EXHIBITION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02550

## 2562 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		LENGTH OF STAY (in this place) <u>45yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bernoudy Rd.</u>				STREET ADDRESS (If rural give location) <u>Bernoudy Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Ellen</u> (Last) <u>Fogle</u>				(Month) <u>May</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>1-31-1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas O'Keefe</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Miss Lillian H. Fogle, White Hall, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> , to <u>May 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>G. M. France</u>				DATE SIGNED <u>3/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-8-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Josephs Catholic</u>		LOCATION (City, town, or county) (State) <u>Texas, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3-8-56</u>		REGISTRAR'S SIGNATURE <u>Wenath W. Markline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Scott Brooks</u>		ADDRESS <u>Sparks, Md.</u>	

0520

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# DEATH CERTIFICATE

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

BUREAU V. R.

MAR 12 1956

RECEIVED

RECEIVED  
BUREAU OF VITAL STATISTICS  
BALTIMORE, MARYLAND  
MARCH 12 1956



MARYLAND STATE DEPARTMENT OF HEALTH

02551

2563

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>LUTHERVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LUTHERVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>802 MORRIS AVE.</u>		STREET ADDRESS (If rural, give location) <u>809 MORRIS AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>WILLIAM</u> (Middle) <u>FRASER</u> (Last)	4. DATE OF DEATH <u>MAR. 18</u> (Month) <u>18</u> (Day) <u>1956</u> (Year)	5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WESTERN ELECTRIC</u>	
8. DATE OF BIRTH <u>MAY 19, 1894</u>	9. AGE last birthday <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>	
11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>Thomas Fraser</u>		14. MOTHER'S MAIDEN NAME <u>Beessie McKenzie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Jas. W. Fraser, Lutherville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>MYOCARDIAL INFARCTION</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		<u>1 MIN.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE William A. Pillsbury M.D. (Degree or title) ADDRESS Timonium DATE SIGNED 3/18/56

23. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Cremation</u>	DATE THEREOF <u>Mar. 23, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>
DATE RECEIVED BY LOCAL REG. <u>March 23, 1956</u>	REGISTRAR'S SIGNATURE <u>Anne MacRae</u>	24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

MAR 27 1956

RECEIVED

2564

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>				d. STREET ADDRESS <u>York Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M.</u> Last <u>Frederick</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Elvina Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-6878</u>		17. INFORMANT <u>Curtis Frederick, Parkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastases</u> <u>1977X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept. 1955</u> , to <u>Mar. 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 11</u> , 19 <u>56</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Hall Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>3/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Pickett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

5834

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 20 1956

RECEIVED

2565

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Parkville	COUNTY	Balto
LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	Parkville
HOSPITAL OR INSTITUTION OR STREET ADDRESS	3039 Woodside Ave.	STREET ADDRESS (If rural give location)	3039 Woodside Ave.,

3. NAME OF DECEASED:			4. DATE OF DEATH:	
(First)	(Middle)	(Last)	(Month)	(Day)
RUDOLF FROHLICH			March	7
19 56				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH:	9. AGE last birthday:
male	white		Mac. 23, 1887	68 yrs.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Carpenter			Austria	U.S.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:	
Unknown			Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
no			Charles R. Frohlich, son, above	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) Coronary Thrombosis		15 Minutes
Antecedent causes (s) (b) Cerebral Accidents		7 Months
(c)		

11. OTHER SIGNIFICANT CONDITIONS		19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from Nov. 1955, to March 1956, that I last saw the deceased alive on Mar 5, 1956, and that death occurred at 8:45 P.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Harold H. Burns		March 9, 1956	
(Degree or title)		ADDRESS	
M.D.		8106 Harbor Bld.	
23. BURIAL, CREMATION, REMOVAL, Burial (Specify)		LOCATION (City, town, or county) (State)	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
March 10, 1956		Oak Lawn Cem.	
DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
March 9, 1956		Schimunek Funeral Home, Inc.	
REGISTRAR'S SIGNATURE		ADDRESS	
J. W. Hedrich		2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2566

## CERTIFICATE OF DEATH

02554  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1912 CECIL AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>D.</b> Last <b>GAINES</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-99</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METAL CLEANER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAG &amp; PAPER CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE GAINES</b>				14. MOTHER'S MAIDEN NAME <b>LAURA CHASE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>  <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>MARCH 17</b> , 19 <b>56</b> , to <b>MARCH 19</b> , 1956, that I last saw the deceased alive on <b>18</b> , and that death occurred at <b>1:12 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. S. Dickey</b>				M.D. <b>VAH FT. HOWARD, MD</b>			
PHYSICIAN'S NAME (Type) <b>FRANCIS D. DICKEY, M.D.</b>				DATE SIGNED <b>3/19/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-22-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. Locke, Jr.</b>				ADDRESS <b>1304 N. Central Ave. Balto.</b>		24a. REC'D BY REGISTRAR <b>March 22, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Dawson L. Furberg</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 22 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2567

## CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Mt Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6719 Broadview Rd.</u>		d. STREET ADDRESS <u>2007 Smith AVE</u>	
3. NAME OF DECEASED (Type or print) <u>DELLA F GAMBRILL</u>		4. DATE OF DEATH <u>MARCH 20 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 13-1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM NAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA CURTIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>George GAMBRILL</u>	
17. INFORMANT <u>George GAMBRILL</u>		Address <u>2007 Smith AVE Mt Washington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis &amp; Auricular fibrillation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal disease</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> , to <u>Mar 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 19</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D.		ADDRESS (Street, city or town, state) <u>115 E. Cager St.</u> DATE SIGNED <u>3-21-56</u>	
PHYSICIAN'S NAME (Type) <u>Frank W Setz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FALLS RD METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>BUTLER-BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank W Setz</u> ADDRESS <u>814 W 36 St Balto 11 MD</u>		24a. REC'D BY REGISTRAR <u>DATE</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Dorothy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 23 1956

RECEIVED

BUREAU V. T.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02556

## 2568 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>ANNE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
53 TOWN <u>DUNDALK 22</u>		3 MO.		TOWN <u>ANNE</u>		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>242 RIVERVIEW AVE</u>				<u>#1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>FLORENCE ROCK GARRETT</u>				(Month) (Day) (Year) <u>3-13-1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 30, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>HOUSEWIFE</u>				<u>HOME</u>		<u>MARYLAND</u>	
13. FATHER'S NAME <u>FREDK. GARRETT</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>NORMAN GARRETT - SAME</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Generalized Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adeno Carcinoma of the Colon</u>						<u>3 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertension Cardiovascular disease</u>						<u>5 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 9</u> , 19 <u>56</u> , to <u>Mar 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eugene F Nevey</u>				ADDRESS (Street, city, town, state) <u>7001 Mornington Rd Dundalk, Md</u>			
DATE <u>3/16/1956</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/16/1956</u>		NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Bradley</u>		ADDRESS <u>Dundalk, Md</u>	
DATE <u>3/16/1956</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# 3558 CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT THE DECEASED WAS

AT THE TIME OF DEATH

NAME AND

RESIDENCE OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF ASSISTANT

NAME OF NURSE

NAME OF DOCTOR

NAME OF PATHOLOGIST

NAME OF ANATOMIST

NAME OF HISTOLOGIST

NAME OF BACTERIOLOGIST

NAME OF VIROLOGIST

NAME OF IMMUNOLOGIST

NAME OF EPIDEMIOLOGIST

NAME OF STATISTICIAN

NAME OF LABORATORY

NAME OF EQUIPMENT

NAME OF SUPPLIES

NAME OF PERSONNEL

NAME OF FACILITIES

NAME OF SERVICES

NAME OF PROGRAMS

NAME OF ACTIVITIES

NAME OF EVENTS

NAME OF OCCASIONS

NAME OF CELEBRATIONS

NAME OF FESTIVALS

NAME OF CONFERENCES

NAME OF SYMPOSIUMS

NAME OF SEMINARS

NAME OF WORKSHOPS

NAME OF TRAINING

NAME OF EDUCATION

NAME OF RESEARCH

NAME OF DEVELOPMENT

NAME OF INNOVATION

NAME OF CREATION

NAME OF IMAGINATION

NAME OF INSPIRATION

NAME OF MOTIVATION

NAME OF ENTHUSIASM

NAME OF PASSION

NAME OF DEDICATION

NAME OF COMMITMENT

NAME OF RESPONSIBILITY

NAME OF ACCOUNTABILITY

NAME OF OBLIGATION

NAME OF DUTY

NAME OF TASK

NAME OF ASSIGNMENT

NAME OF PROJECT

NAME OF INITIATIVE

NAME OF ENTERPRISE

NAME OF VENTURE

NAME OF ADVENTURE

NAME OF EXPLORATION

NAME OF DISCOVERY

NAME OF INVENTION

NAME OF CREATION

NAME OF IMAGINATION

NAME OF INSPIRATION

NAME OF MOTIVATION

NAME OF ENTHUSIASM

NAME OF PASSION

NAME OF DEDICATION

NAME OF COMMITMENT

NAME OF RESPONSIBILITY

NAME OF ACCOUNTABILITY

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NAME OF ACCOUNTABILITY

NAME OF OBLIGATION

NAME OF DUTY

NAME OF TASK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, Film G194 3-19-56 et

2569

## CERTIFICATE OF DEATH

Reg. Dist. No.

02557

43

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Belhaven Drive</b>		d. STREET ADDRESS <b>14 Belhaven Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Filippina</b> First <b>Giannetta</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>12th</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1884</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Joseph Ferrari</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Greco</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. John Arena, 14 Belhaven Drive, #6</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Regeneration</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/2/1956</b> , to <b>3/11/1956</b> , that I last saw the deceased alive on <b>3/11/1956</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Max Quinn</b> M.D.		ADDRESS (Street, city or town, state) <b>1927 York Rd, TIMONUM</b> DATE SIGNED <b>3/12/56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 15, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery Asso.</b>		22d. LOCATION (City, town, or county) (State) <b>Irvington, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>3/14/56</b> 24b. REGISTRAR'S SIGNATURE <b>Mrs. d. L. Reifsonider</b>	

CERTIFICATE OF DEATH

3258

DEPARTMENT OF HEALTH BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE	
DATE OF DEATH 1956		DATE OF DEATH 1956	
PLACE OF DEATH 1000 ... Drive		PLACE OF DEATH 1000 ... Drive	
NAME OF DECEASED ...		NAME OF DECEASED ...	
SEX Male		SEX Male	
AGE 35		AGE 35	
RACE White		RACE White	
OCCUPATION ...		OCCUPATION ...	
CAUSE OF DEATH ...		CAUSE OF DEATH ...	
MANNER OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF PHYSICIAN ...	
SIGNATURE OF REGISTRAR ...		SIGNATURE OF REGISTRAR ...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2570

## CERTIFICATE OF DEATH

02558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2508 Taylor Avenue</b>				d. STREET ADDRESS <b>2508 Taylor Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Mr. Henry W. Gleim</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20th</b> Year <b>1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1883</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Linotype Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Charles F. Gleim</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Kohlman</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>213-03-2638</b>				17. INFORMANT <b>Mrs. Katherine W. Gleim, 2508 Taylor Ave #14</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma w/ extensive metastases</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Anemia severe</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 1954, to <b>20 March</b> , 1956, that I last saw the deceased alive on <b>20 March</b> , 1956, and that death occurred at <b>11:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward L. J. Moitz</b>				ADDRESS (Street, city or town, state) <b>7425 Harford Rd.</b>		DATE SIGNED <b>21 March 56</b>	
PHYSICIAN'S NAME (Type) <b>EDWARD L. J. MOITZ M.D.</b>				Baltimore 14 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				24a. REC'D BY REGISTRAR <b>DATE 22 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. R. M. Bacon</b>	

**THE UNIVERSITY OF CHICAGO PRESS**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02559

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2702 Old North Point Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gray Manor</u> d. STREET ADDRESS <u>2702 Old North Point Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LEROY</u> Middle <u>H.</u> Last <u>GODWIN</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>13</u> Year <u>1956</u>					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 10, 1894</u>		<b>9. AGE</b> (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Concrete Products - Manufacturer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Harford Co., Md.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Benjamin J. Godwin</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Kate A. Hooker</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>---</u>		<b>17. INFORMANT</b> Address <u>Gladys M. Godwin, 2702 Old North Point Rd.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Heart</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>M B Davis</u>				<b>EXAMINER'S NAME (Type)</b> <u>M. B. DAVIS</u>				<b>DATE SIGNED</b> <u>3/15/56</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>				<b>22b. DATE THEREOF</b> <u>3/17/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm Cook, Inc.</u>				<b>ADDRESS</b> <u>1217 St. Paul Street</u>		<b>24a. REC'D BY REGISTRAR</b> <u>  </u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mr. Edith Hurley</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
3271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 104

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G193 3-6-56 et

2572

## CERTIFICATE OF DEATH

Reg. Dist. No.

02560

49

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>66 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u>	<u>23X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>107 Purnell Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WINFRED W. GOSWELLIN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 4 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>7/21/24</u>
9. AGE last birthday: <u>31</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Lumber Company</u>	
11. BIRTHPLACE (State or foreign country): <u>Snow Hill, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Clarence Goswellin</u>		14. MOTHER'S MAIDEN NAME: <u>Cynthia Hearne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes Korean</u>		16. SOCIAL SECURITY NO. <u>214 18 4314</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
IMMEDIATE CAUSE (A) <u>RETICULUM CELL SARCOMA</u>			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that <u>VA</u> attended the deceased from <u>Dec. 29, 1955</u> , to <u>Mar. 4, 1956</u> that I last saw the deceased <u>and that death occurred at 12:25 M.</u>			
SIGNATURE <u>C. GONZALEZ, M.D.</u>		DATE SIGNED <u>3/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-7-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Whitcote Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR, ADDRESS <u>Clarence E. Dennis Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		<u>Snow Hill, Maryland</u>	

100

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02561

2573

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Roberts Avenue</u>				STREET ADDRESS (If rural give location) <u>10 Roberts Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
OF DEATH: <u>Oliver Harrison Gray</u>				OF DEATH: <u>3 20 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>6/1/1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Janitor</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>George H. Gray</u>				14. MOTHER'S MAIDEN NAME: <u>Harriett ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				17. INFORMANT & ADDRESS: <u>Mrs. Sadie Gray - 10 Roberts Avenue</u>			
16. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>4421 Cardio Vascular Renal Disease -</u>							
IMMEDIATE CAUSE (A) <u>Hypertensive</u>				1 yr.			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>54</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 18 1956</u> , and that death occurred at <u>5 P:M</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. L. Jackson</u>				ADDRESS <u>600 N. Arlington Ave.</u>		DATE SIGNED <u>3/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/24/56</u>		<u>Liberty Cemetery</u>		<u>Liberty, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-23-56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		ADDRESS <u>1000 Brantley Ave</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02562

2574

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN lb <b>11mos. 13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3520 Hilton Road</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Grebe</b>		4. DATE OF DEATH <b>March 7, 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 4, 1868</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Grebe</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right pyelitis and lithiasis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-23</b> , 19 <b>55</b> , to <b>3-7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3-7</b> , 19 <b>56</b> , and that death occurred at <b>3:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. Glyne Williams</b>		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital Catonsville 28, Maryland</b>	
DATE SIGNED <b>3-7-56</b>			
PHYSICIAN'S NAME (Type) <b>T. Glyne Williams, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 10, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>MAR 8 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>T. E. Harry</b>			

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Usual Residence		Place of Death		Cause of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1/1/1900		Male		White		Married		Teacher		123 Main St, Baltimore, Md.		123 Main St, Baltimore, Md.		Heart Disease		1/15/1950		10:00 AM		J. Doe, M.D.		J. Doe, Registrar	

BUREAU V. S.

MAR 9 1950

RECEIVED

123 Main St, Baltimore, Md.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9755

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		c. LENGTH OF STAY IN 1b <u>8 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2802 Lingamore Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Phyllis</u> First Middle Last <u>Griffith</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>9</u> - Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20 - 1930</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RALPH-R-ROSIER</u>		14. MOTHER'S MAIDEN NAME <u>GLADYS BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-26-1109</u>	
17. INFORMANT <u>ELLWOOD R. GRIFFITH</u>		Address <u>1918 Kelmore Rd</u> <u>W. IRVENESS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>P</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William H. Griffith</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-13-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Rayville Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Seitz</u>		24a. REC'D BY REGISTRAR <u>Mr. R. M. Bacon</u>	
ADDRESS <u>814 N. 31st St</u> <u>Baltimore City, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. R. M. Bacon</u>	

DATE MAR 12 1956

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED GARY R. ROSSIER		AGE 35		SEX M		RACE W		DATE OF BIRTH MAY 20 1902	
RESIDENCE 1918 BELMONT ROAD		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		DATE OF DEATH MAY 20 1902	
OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH HOME		DATE OF EXAMINATION MAY 20 1902	
SIGNATURE OF EXAMINER W. J. H. HARRIS		SIGNATURE OF DECEASED GARY R. ROSSIER		SIGNATURE OF WITNESS CLAYTON BAKER		SIGNATURE OF WITNESS W. J. H. HARRIS		SIGNATURE OF WITNESS W. J. H. HARRIS	

BUREAU V. S.

MAR 13 1906

RECEIVED

THE STATE DEPARTMENT OF HEALTH  
 BALTIMORE, MD.

2576

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland, U.S.A.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>02 Mt. Wilson State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> x			
f. STREET ADDRESS <b>20 Denton Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Hartmann</b> Last <b>Hartmann</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-29-1894</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jacob Gurlach</b>				14. MOTHER'S MAIDEN NAME <b>Minnie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Mt. Wilson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>002X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Mt. Wilson, Maryland</b>				20g. (County) <b>Colgate, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>3/27</b> , 19 <b>56</b> , to <b>3/31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/31</b> , 19 <b>56</b> , and that death occurred at <b>2. a.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b> ACTUAL SIGNATURE <b>WM. NEWCOMER, M. D.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>				24a. REC'D BY REGISTRAR <b>APR 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

25 10

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

DATE OF DEATH

<p>1. NAME OF DECEASED                  Mr. Wilson, John</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  65 years</p>		<p>4. DATE OF BIRTH                  1884</p>	
<p>5. PLACE OF BIRTH                  Boston, Mass.</p>		<p>6. OCCUPATION                  Carpenter</p>	
<p>7. MARITAL STATUS                  Married</p>		<p>8. DATE OF MARRIAGE                  1910</p>	
<p>9. NAME OF SPOUSE                  Mrs. Wilson, Mary</p>		<p>10. DATE OF DEATH                  April 3, 1956</p>	
<p>11. PLACE OF DEATH                  Home</p>		<p>12. CAUSE OF DEATH                  Heart Disease</p>	
<p>13. MEDICAL HISTORY                  Hypertension, Atherosclerosis</p>		<p>14. SIGNATURE OF PHYSICIAN                  Dr. J. H. Smith</p>	
<p>15. SIGNATURE OF DECEASED                  John Wilson</p>		<p>16. SIGNATURE OF WITNESSES                  Mary Wilson, John Wilson</p>	

BUREAU V. S.

APR 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2577

## CERTIFICATE OF DEATH

03700

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>				c. LENGTH OF STAY IN Ib <b>8yr4mos25days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bessie T. Harvey</b>				4. DATE OF DEATH <b>March 27, 19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-25-1877</b>	
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Tyus Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Anna Salter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Generalized arteriosclerosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>7-</b> _____, <b>19 53</b> , to <b>3-27-</b> _____, <b>19 56</b> , that I last saw the deceased alive on <b>3-27-</b> _____, <b>19 56</b> , and that death occurred at <b>8:20P M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D.				ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>3-28-56</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3/29/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Univ. Md. Med. School</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____				24a. REC'D BY REGISTRAR _____		24b. REGISTRAR'S SIGNATURE <b>V. E. Harry</b>	



BUREAU V. S.

APR 25 1956

RECEIVED



2578

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Colgate</u>				TOWN <u>Colgate</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7603 Riddle Ave.</u>				STREET ADDRESS (If rural give location) <u>7603 Riddle Ave.</u>			
3. NAME OF DECEASED: (First) <u>MAMIE</u>		(Middle) <u>HAYNES</u>		(Last) <u>HAYNES</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 12, 1877</u>	9. AGE last birthday: <u>78</u> yrs.	10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>  </u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John White</u>				14. MOTHER'S MAIDEN NAME: <u>Maria Davies</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u>  </u>		17. INFORMANT & ADDRESS: <u>Archie Haynes 7603 Riddle Ave.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>592X</u> Immediate cause (a) <u>Uremia</u>						<u>10</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Chronic Interstitial Nephritis</u>						<u>1 year</u>	
(c) <u>Hy pertension</u>						<u>10 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>  </u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1955</u> to <u>March 14, 1956</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Morris G. Jacobson MD</u>				DATE SIGNED <u>3/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 17, 1956</u>		<u>Oak Lawn</u>		<u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>MAR 19 1956</u>		<u>Mrs. Edith Hurley</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

RECEIVED

MAR 20 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2579

## CERTIFICATE OF DEATH

02566/1

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1412 Regester Avenue</b>				d. STREET ADDRESS <b>1412 Regester Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Lynn</b> Last <b>Hays</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 9, 1951</b>	
9. AGE (In years last birthday) <b>-4-</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Richard U. Hays</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Lee Maglidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <b>Richard U. Hays (Father) 1412 Regester Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Nephritis</b> DUE TO (c) <b>Nephrosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May</b> , 19 <b>53</b> , to <b>Mar 28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Mar 28</b> , 19 <b>56</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harriet G. Guild</b>				ADDRESS (Street, city or town, state) <b>Johns Hopkins Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Harriet G. Guild</b>				DATE SIGNED <b>Johns Hopkins Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				24a. REC'D BY REGISTRAR <b>April 2, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

BUREAU V. S.

APR 2 1956

RECEIVED

## 2580 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, Film 19, 1-2-56 et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Bethlehem Steel Co. Dispensary</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> , Sparrows Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u> ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>				d. STREET ADDRESS <u>3830 Falls Road</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Henderson</u>				4. DATE OF DEATH <u>3-1-56</u> Month <u>3</u> Day <u>1</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u> <u>July 2, 1891</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Henderson.</u>				14. MOTHER'S MAIDEN NAME <u>Dora Phillips.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie G. Henderson.</u> Address <u>3830 Falls Road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's, Hampden</u>		22d. LOCATION (City, town, or county) (State) <u>3900 Roland Ave, Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>				24a. REC'D BY REGISTRAR <u>March 15 1956</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 19 1956

RECEIVED



2581

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Upperco</u>	LENGTH OF STAY (in this place) <u>5 Wks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Upperco</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Upperco, MD - R.F.D. #1</u>		STREET ADDRESS (If rural give location) <u>R.F.D. #1 - Upperco, MD.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>ANNA</u>	(Middle) <u>M.</u>	(Last) <u>Henry</u>	DATE OF DEATH: <u>March 30</u> 19 <u>56</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 22, 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>— — — —</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Lawrence Sands</u>		14. MOTHER'S MAIDEN NAME: <u>Mary White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Lawrence Henry - Upperco, MD - R.F.D. #1</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>			<u>3 days</u>
ANTECEDENT CAUSE (S) (B) <u>Cerebral Arterio-Sclerosis</u>			<u>4-5 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 5</u> , 19 <u>55</u> , to <u>March 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 29</u> , 19 <u>56</u> , and that death occurred at <u>109</u> M, from the causes and on the date stated above.			
SIGNATURE <u>M.C. Porterfield</u>		ADDRESS <u>Stamptown, MD</u> DATE SIGNED <u>3-30-56</u>	
M.D. <u>Stamptown, MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/2/56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Stephen's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bradshaw, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 31, 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. & J. B. BOND  
EAGLE BRAND

COMMON SENSE

2582

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>9 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robt Nursing Home Essex Rd.</u>		STREET ADDRESS (If rural give location) <u>4304 Kensington Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNA M. Herget</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 30 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>3-24-1885</u>
9. AGE last birthday: <u>71</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Amusements Home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Karl Maag</u>		14. MOTHER'S MAIDEN NAME: <u>Lena Schroeder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Henry Spatis, Stevenson P.O. Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>cerebral vascular accident</u>			<u>6 wks.</u>
ANTECEDENT CAUSE (B) <u>arteriosclerotic heart disease</u>			<u>3 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 1955, to <u>30 Mar</u> , 1956, that I last saw the deceased alive on <u>29 Mar</u> , 1956, and that death occurred at <u>10A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Paul H. Royle</u>		ADDRESS <u>Pikesville 8 Md.</u>	
DATE SIGNED <u>30 Mar 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/2/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Western</u>		LOCATION (City, town, or county) (State) <u>Edmondson Ave. Balto, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-2-56</u>		REGISTRAR'S SIGNATURE <u>North a. Knull</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Frank H. Newell Pikesville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COLLATERAL  
VEGETABLE BOND  
A-310A3

BUREAU V. S.

APR 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Certificate has been signed by the attending physician and correctly filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02569

2583

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8339 Phila. Rd.</b>				d. STREET ADDRESS <b>8339 Phila. Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Albert A. Herrmann</b>				4. DATE OF DEATH <b>March 15, 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1893</b>		9. AGE (In years last birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Bar</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Edward Herrmann</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Neumeister</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>216-28-1525</b>				17. INFORMANT <b>Mrs. Myrtle C. Herrmann-8339 Phila. Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.				20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>8/27/55</b> , 19____, to <b>3/15/56</b> , 19____, that I last saw the deceased alive on <b>3/15/56</b> , 19____, and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George D. Edwards</b> M.D.				ADDRESS (Street, city or town, state) <b>8019 Philadelphia Road, Balto. 6</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>George D. Edwards, M.D.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>Mar. 18, 1956</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran</b>			
22d. LOCATION (City, town, or county) (State) <b>Stemmers Run, Balto. Md.</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanshan Funeral Home - 7401 Belair Rd.</b>			
24a. REC'D BY REGISTRAR <b>MAR 19 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Mrs. Edith L. Lively</b>			

RECEIVED



2584

## CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>2 1/4 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>02 Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>3218 ELMLEY AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>IGNATIUS</b> Middle <b>MORTIMER</b> Last <b>HESTER</b>				4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1928 12-29-12</b>	
9. AGE in years (last birthday) <b>28</b> yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUS OPERATOR</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>PETER WILLIAM HESTER</b>				14. MOTHER'S MAIDEN NAME <b>EMMY WHEATLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-1062</b>		17. INFORMANT Address <b>Hospital Records Mt. Wilson, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY FIBROSIS</b> DUE TO (c) <b>PULMONARY TUBERCULOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 3/4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIC SCLEROSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-20-1954</b> to <b>3-25-1956</b> , that I last saw the deceased alive on <b>3-25-1956</b> , and that death occurred at <b>9-20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>WM. NEWCOMER, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR 28 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME</b>				ADDRESS <b>4210 BELAIR</b>		24a. REC'D BY REGISTRAR <b>March 28, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dorothy Powell</b>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 28 1956  
BUREAU V. 3

MAR 28 1956

BUREAU V.

2585

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarm</b>			c. LENGTH OF STAY IN 1b <b>life</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stoney Batter Road</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MYRTLE R. HIENER</b>			4. DATE OF DEATH Month <b>March</b> Day <b>30th</b> Year <b>1956</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1910</b>		9. AGE (In years last birthday) <b>45 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>-- Drenner</b>			14. MOTHER'S MAIDEN NAME <b>May Sadler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. Edw. Hiener, Stoney Batter Rd., Glenarm, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443K Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c) <b>Pulmonary Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>10 yrs.</b> <b>5 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lung</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 8, 1938</b> to <b>Mar. 30, 1956</b> , that I last saw the deceased alive on <b>March 29, 1956</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fork, Md.</b> DATE SIGNED <b>3/31/56</b> ACTUAL SIGNATURE <b>Clifford F. Hudson</b> PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON FORK, MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/2/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Belair, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Laasohn Funeral Home</b>			ADDRESS <b>7401 Belair Road</b>		24a. REC'D BY REGISTRAR <b>April 2, 1956</b>
24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

APR 2 1956

## MARYLAND STATE DEPARTMENT OF HEALTH

02572

2411 N. Charles Street, Baltimore

2586

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CARNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CARNEY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3219 E Joppa Rd</u>		STREET ADDRESS (If rural, give location) <u>3219 E Joppa Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>LINDA</u> (First) <u>DARLENE</u> (Middle) <u>HILTON</u> (Last)	4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>10</u> (Year) <u>1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT 4 1954</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>COLEMAN L HILTON</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA VAUGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>  </u>	
17. INFORMANT <u>Barbara Hilton 3219 E. Joppa Rd</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

325.5 Immediate cause

(a)

TAY-SACHS DISEASE

INTERVAL BETWEEN ONSET AND DEATH

From birth

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1955, to Mar 10, 1956, that I last saw the deceased alive on Mar 9, 1955, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

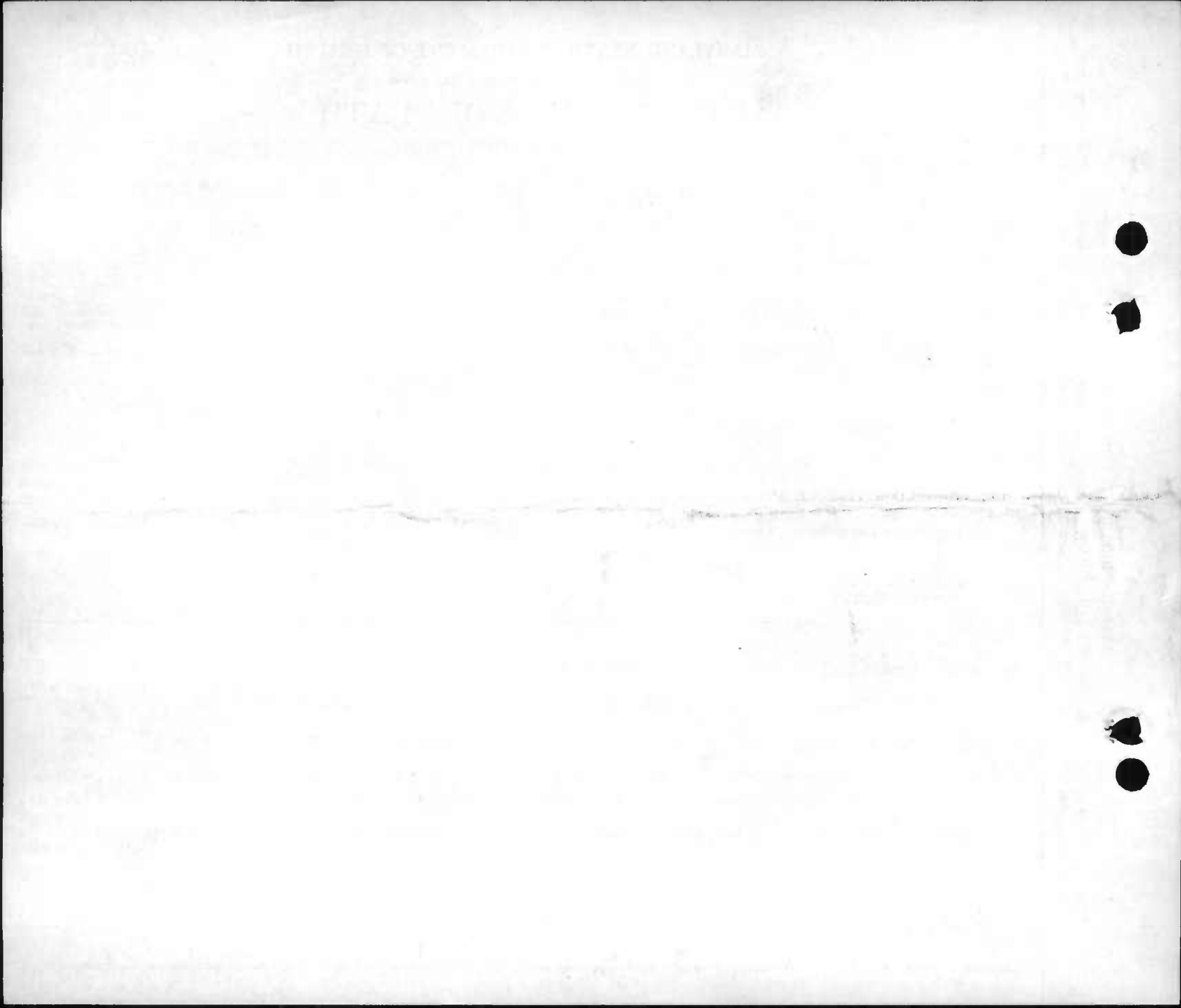
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3-13-56</u>	NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	LOCATION (City, town, or county) <u>BALTO</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>3-12-56</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>CHARLES EVANS &amp; SON</u>		
		ADDRESS <u>8808 Hartford Rd</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02573

## 2587 CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Nunnery Lane</u>				STREET ADDRESS (If rural give location) <u>10 Nunnery Lane</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>CHARLES</u> (Middle) <u>ANDREW</u> (Last) <u>HOFFNAGLE</u>				(Month) <u>March</u> (Day) <u>21</u> (Year) <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 7, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Rhinehardt Hoffnagle</u>				14. MOTHER'S MAIDEN NAME <u>Martha Frank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, cause war or dates of service) <u>yes</u> <u>World War No. 1</u>				16. SOCIAL SECURITY NO. <u>216-32-6003</u>		17. INFORMANT & ADDRESS <u>Mrs. Mildred H. Hoffnagle</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-2</u> , 19 <u>48</u> , to <u>3-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leon Ashman</u>				DATE SIGNED <u>5907 Surgeon Oak Ave Balts 7, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/26/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Catonsville Md.</u>	
24. REC'D BY REGISTRAR <u>March 23, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balts 7, Md.</u>		ADDRESS	

MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2588 CERTIFICATE OF DEATH

02574  
W

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>				c. LENGTH OF STAY IN 1b <b>15 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8124 Philadelphia Rd</b>				d. STREET ADDRESS <b>8124 Philadelphia Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Hoover</b> Last <b>Hoover</b>				4. DATE OF DEATH Month <b>3</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1880</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hostler</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jake Hoover</b>				14. MOTHER'S MAIDEN NAME <b>Mary Boone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Catherine M. Hoover-8124 Philadelphia Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/25</b> , <b>1953</b> , to <b>3/16</b> , <b>1956</b> , that I last saw the deceased alive on <b>3/16/56</b> , <b>19</b> , and that death occurred at <b>9:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George D. Edwards</b>				ADDRESS (Street, city or town, state) <b>8019 Philadelphia Rd., Balto., Md.</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE D. EDWARDS, M.D.</b>				DATE SIGNED <b>3/16/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louisa Funeral Home - 7401 Belair Rd.</b>				ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Edith Shirley</b>	
				24a. REC'D BY REGISTRAR <b>MAR 19 1956</b>		DATE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02575  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1406 E. Biddle Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EARL HOWARD</u>				4. DATE OF DEATH Month Day Year <u>March 29 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 18, 1925</u> 30 yrs.	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fuel Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Sampson Co., N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Howard</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>239-32-7874</u>		17. INFORMANT <u>Clinical Records, Vet. Adm. Hosp. Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRACHEO BRONCHIAL OBSTRUCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CONGENITAL ANOMALY AND INTRODUCTION OF DRUG (DIONASIL)</u> (c) <u>CHRONIC TRACHEITIS AND BRONCHIECTASIS</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enlarged thymus and atrophic adrenals</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Convulsions during Bronchogram</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Locks, Jr.</u>				24a. REC'D BY REGISTRAR <u>March 30, 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>David L. Fisher</u>			



MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. 1

APR 2 1956

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

02576

2590

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>BALTO</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>LODGE FOREST (19)</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>LODGE FOREST</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7740 S. COVE Rd.</b>		STREET ADDRESS (If rural, give location) <b>7740 S. COVE Rd.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>OSCAR</b>	(Middle)	(Last) <b>HUOPONEN</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 17, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GENERAL LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFR</b>	9. AGE last birthday <b>64</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. HUOPONEN</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-36881</b>	
17. INFORMANT <b>MATILDA HUOPONEN</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.0</b> Immediate cause (a) <b>Coronary Occlusion</b> Antecedent cause(s) (b) <b>Atherosclerotic H. D.</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>5 yrs -</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>Jack E. Collins M.D.</b>		ADDRESS <b>9 Henship Balt 22</b>	
DATE SIGNED <b>3-28-52</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>3-30-52</b>	
NAME OF CEMETERY OR CREMATORY <b>BELEIR MEM.</b>		LOCATION (City, town, or county) (State) <b>BELEIR, Md.</b>	
DATE REC'D BY LOCAL REG. <b>2 1952</b>		24. FUNERAL DIRECTOR <b>Dawson L. Farley With Sons, Bel Air, Md.</b>	

RECEIVED

APR 3 1956

BUREAU V. S.

2591

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY <b>Balto</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>2 m.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntingtown</b> <b>04X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Olen</b> Middle <b>Edward</b> Last <b>Ireland</b>		4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10.11.80</b>
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edward Ireland</b>		14. MOTHER'S MAIDEN NAME <b>Elisabeth Gibson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Address <b>Spring Grove Hosp.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic nephrosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>3-26-</b> 19 <b>56</b> , and that death occurred at <b>11</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslor</b> M.D.		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>3-27-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel</b>	22d. LOCATION (City, town, or county) (State) <b>Calvert Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Hartness</b>		ADDRESS <b>Mistral Md</b>	24. REC'D BY REGISTRAR <b>March 29, 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>V. E. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 29 1956

BUREAU V. S.

Form with multiple sections and fields, including a large central area with a diagonal line and various smaller sections at the top and bottom.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2592

## CERTIFICATE OF DEATH

02578

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Ta. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington (23) 16X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 SPRING GROVE STATE HOSP</b>				d. STREET ADDRESS <b>413 Allies Road, S.E.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWIN FRED JACKEMEYER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 12 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1905</b>		9. AGE (In years lost birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>INDIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>MARINES '30-34 -</b>		17. INFORMANT <b>Records of Spring Grove State Hosp.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Huntington's Chorea</b> <b>355X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 30, 1953</b> , to <b>Mar. 12, 1956</b> , that I last saw the deceased alive on <b>March 12, 1956</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerome E. Shapiro</b> M.D.				ADDRESS (Street, city or town, state) <b>Spring Grove Hosp. Baltimore, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Jerome E. Shapiro</b>				DATE SIGNED <b>3/12/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 16, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson</b>				ADDRESS <b>6300 N. St. L.</b>		24a. REC'D BY REGISTRAR <b>DATE 3/13/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>V. E. Harry</b>			

BUREAU V. S.

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02579

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2593

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pines 16 Fusting Ave.</u>		STREET ADDRESS (If rural, give location) <u>10 E. Henrietta St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Margaret</u> (Middle) <u>Jewell</u> (Last)		4. DATE OF DEATH (Month) <u>3/5/56</u> (Day) (Year) <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 23, '67</u> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Benjamin Davis</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Estelle Bowden 10 E. Henrietta</u>	

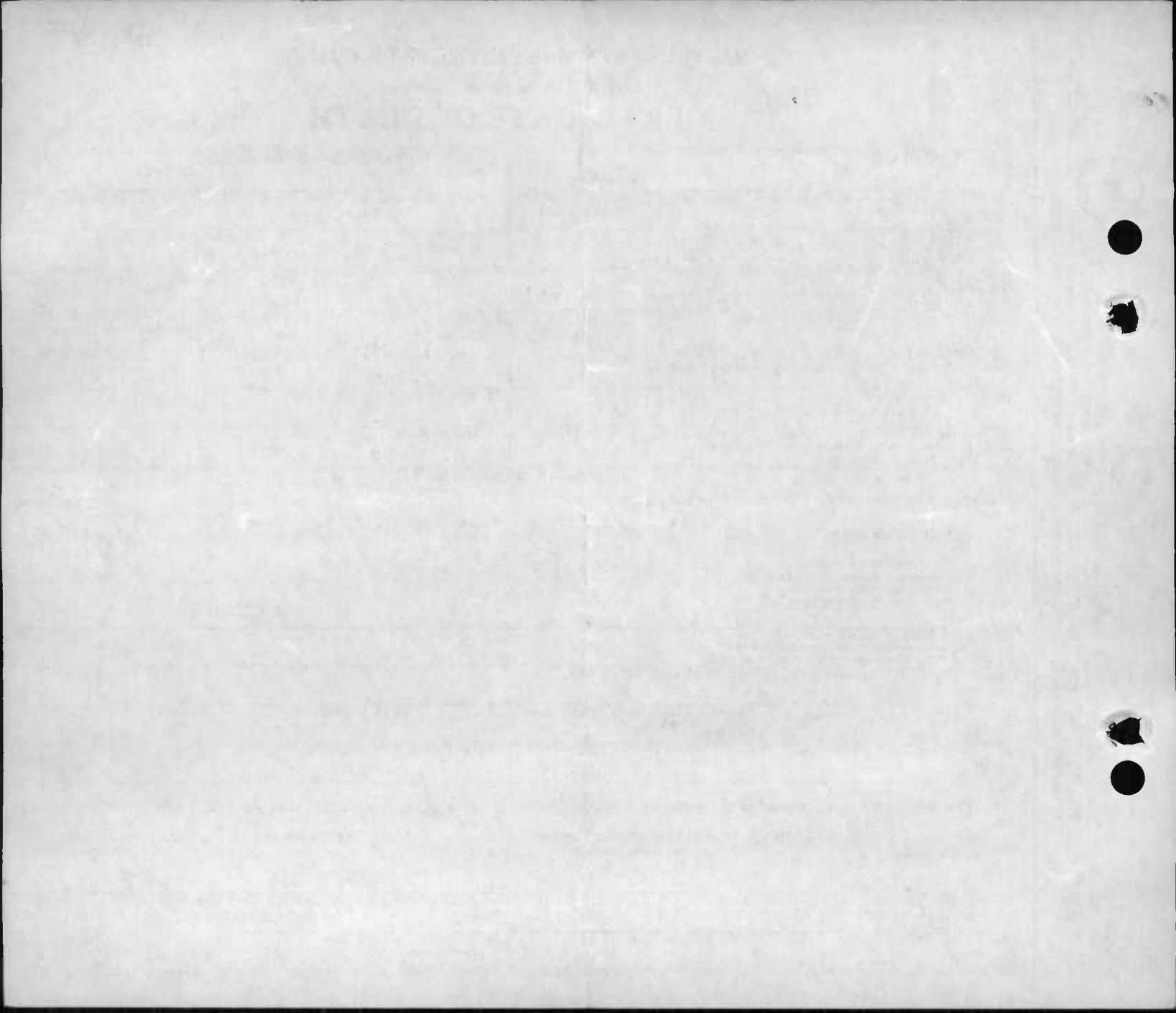
## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Cervical cancer</u>			<u>Minutes</u>
Antecedent cause(s) (b) <u>General debility</u>			<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Prostatic Pt. hyp - debility</u>			<u>3 Months</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 5, 1955</u> to <u>2/26, 1956</u> , that I last saw the deceased alive on <u>2/26, 1956</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. B. Brown M.D.</u>		ADDRESS <u>3/6/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/7/56</u>	
DATE REC'D BY LOCAL REG. <u>3/6/56</u>		REGISTERAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>		ADDRESS <u>715 Light St. Baltimore 30, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02580

## 2594 CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWN Towson</u>		LENGTH OF STAY (in this place) <u>45 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWN Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 E. Joppa Road</u>				STREET ADDRESS (If rural give location) <u>200 E. Joppa Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>GEORGE SEYMOUR JOHNSON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 18, 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>March 30, 1886</u>	<b>9. AGE last birthday</b> <u>69</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Houseman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Private Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Family records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary artery occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>MAR 18, 1956</u> , to <u>MAR 18, 1956</u> , that I last saw the deceased alive on <u>Mar 18, 1956</u> , and that death occurred at <u>2:35</u> P.M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Thaddaea C. Swinicki</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. 17 W. Panna Ave Towson</u>		<b>DATE SIGNED</b> <u>3/19/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 20, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Rest Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Towson, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mabel C. Gray</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burren'son</u>		<b>ADDRESS</b> <u>Towson, Maryland</u>	
<b>DATE</b> <u>Mar. 20, 1956</u>							

# STATE OF NEW YORK DEPARTMENT OF HEALTH - ALBANY, N.Y. CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		45		March 1, 1910		New York		New York		New York		New York	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH	
Carpenter		Heart Disease		Natural		New York		New York		New York		New York		March 10, 1956	
EDUCATION		SCHOOLING		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
High School		8		Roman Catholic		Married		Yes		No		No		No	
MOTHER'S NAME		FATHER'S NAME		MOTHER'S MAIDEN NAME		FATHER'S MAIDEN NAME		MOTHER'S BIRTH		FATHER'S BIRTH		MOTHER'S DEATH		FATHER'S DEATH	
Mary Harris		John Harris		Mary Harris		John Harris		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910	
MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH	
March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910	
MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S DEATH	
March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910		March 1, 1910	

BUREAU V. S.

MAR 22 1956

RECEIVED

Item 2, File 194 3-18-56 et

2595

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH: <i>6811 Camfield Rd - 7</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore Co</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	TOWN <i>Baltimore 18</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Augsburg Home</i>		STREET ADDRESS (If rural give location)	<i>2752 Fenwick Avenue</i>
3. NAME OF DECEASED: (First) <i>Catherine</i> (Middle) <i>Kalhof</i> (Last)	4. DATE (Month) (Day) (Year) OF DEATH: <i>March 8 1956</i>		
5. SEX: <i>female</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>April 19-1967</i>
9. AGE last birthday: <i>88</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>	11. BIRTHPLACE (State or foreign country): <i>Baltimore Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Joseph Dorn</i>	
14. MOTHER'S MAIDEN NAME: <i>UNKNOWN</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>		<i>8 months</i>
ANTECEDENT CAUSE (B) <i>Hypertensive Cardiovascular Disease</i>		<i>5 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Generalized Arterio-sclerosis</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <i>None</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *May*, 1955, to *March 8th*, 1956, that I last saw the deceased alive on *March 1, 1956*, and that death occurred at *9:15* M, from the causes and on the date stated above.

SIGNATURE <i>Paul L. Chambers</i>	ADDRESS <i>4108 Liberty Hts Balto - 7</i>	DATE SIGNED <i>3-9-56</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>	DATE THEREOF <i>3/10/56</i>	NAME OF CEMETERY OR CREMATORY <i>Emanuel Cemetery</i>
LOCATION (City, town, or county) <i>London Ave Balto</i>	24. FUNERAL DIRECTOR <i>PAUL A. HEEMANN</i>	ADDRESS <i>6027 Hayford Rd</i>
DATE REC'D BY LOCAL REGISTRAR <i>3-9-56</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMITTEE



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02582  
20

2596

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Balto. City</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 4mths 13days</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>224 Hazel Avenue - Balto. 27</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>C.</b> Last <b>Kastner</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1894</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A. - Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert Martin</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Mahon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records of SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 25, 1956</b> , to <b>March 14, 1956</b> , that I last saw the deceased alive on <b>March 14, 1956</b> , and that death occurred at <b>3:50 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 3-14-56</b> DATE SIGNED <b>Catonsville 28, Maryland</b>			
ACTUAL SIGNATURE <b>T. Glyne Williams</b> M.D.		PHYSICIAN'S NAME (Type) <b>T. Glyne Williams, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto.</b>		24a. REC'D BY REGISTRAR <b>161958</b>	
24b. REGISTRAR'S SIGNATURE <b>V. E. Harvey</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAR 16 1956

RECEIVED  
APR 16 1956

2597

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>1mo 11days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>J.</b> Last <b>King</b>			4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1876</b>		9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles King</b>			14. MOTHER'S MAIDEN NAME <b>(Winnie) Winifred Cloonan</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>831X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>  <b>years</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 6, 1956</b> to <b>Mar. 17, 1956</b> that I last saw the deceased alive on <b>Mar. 17, 1956</b> and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital, Catonsville, Md.</b> DATE SIGNED <b>3/17/56</b> ACTUAL SIGNATURE <b>T. Glyne Williams</b> M.D. PHYSICIAN'S NAME (Type) <b>T. Glyne Williams</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto</b>			24a. REC'D BY REGISTRAR <b>March 19, 1956</b>		
ADDRESS <b>md</b>			24b. REGISTRAR'S SIGNATURE <b>T. E. Barry</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956

1956

<p>1. NAME OF DECEASED                  JAMES H. HARRIS</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  68 years</p>		<p>4. DATE OF BIRTH                  Jan. 1, 1888</p>	
<p>5. PLACE OF BIRTH                  Baltimore, Md.</p>		<p>6. OCCUPATION                  Retired</p>	
<p>7. MARITAL STATUS                  Married</p>		<p>8. DATE OF MARRIAGE                  May 1, 1910</p>	
<p>9. NAME OF SPOUSE                  Mary H. Harris</p>		<p>10. DATE OF DEATH                  Mar. 1, 1956</p>	
<p>11. PLACE OF DEATH                  1111 Broadway Road</p>		<p>12. CAUSE OF DEATH                  Coronary artery disease</p>	
<p>13. MANNER OF DEATH                  Natural</p>		<p>14. SIGNATURE OF PHYSICIAN                  J. H. Harris</p>	
<p>15. SIGNATURE OF REGISTRAR                  J. H. Harris</p>		<p>16. SIGNATURE OF WITNESSES                  J. H. Harris</p>	

BUREAU V. S.

MAR 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02584

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 52</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 Shipley Ave</u>		d. STREET ADDRESS <u>6 Shipley Ave</u>	
3. NAME OF DECEASED (Type or print) <u>George B King</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17 67</u> 9. AGE (In years last birthday) <u>88</u> yrs.
10a. USUAL OCCUPATION (For kind of work done during most of working life, even if retired) <u>Laborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry King</u>		14. MOTHER'S MAIDEN NAME <u>Antonia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>6 Shipley Ave</u>	
17. INFORMANT <u>Paul King</u> Address <u>6 Shipley Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Acute Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary vascular disease</u> (c) <u>underlying</u> DUE TO <u>cause last.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo M Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo M Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 9 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Boston Star</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rance A Hensley</u> ADDRESS <u>578 W Biddle</u>		24a. REC'D BY REGISTRAR <u>MAR 12 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>V. E. Hays</u>	

DATE SIGNED

Mar 5, 56



*[Faint, mostly illegible handwritten text in the upper section of the form, likely containing patient and death details.]*

BUREAU V. S.

MAR 13 1956

RECEIVED

*[Faint, mostly illegible handwritten text in the lower section of the form, likely containing signatures and dates.]*



2599

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 16</u> 3V01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Spring Grove St. Hospital</u>				d. STREET ADDRESS <u>808 Whittemore Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type in full) First Middle Last <u>(Margaret) Margarete E. KIRBY</u>				4. DATE OF DEATH Month Day Year <u>3 - 24 - 1956</u>			
5. SEX <u>f.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 29<sup>th</sup> 1893</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August HAUCK</u>				14. MOTHER'S MAIDEN NAME <u>Catherine MEIER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mrs Rose NEAL</u>		Address <u>2518 V. Lafayette Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple cerebral accidents</u> DUE TO (c) <u>Malignant Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>  <u>years</u>  <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident 1951</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 16<sup>th</sup></u> , 19 <u>50</u> , to <u>March 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>56</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrude J. Fleischman</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove St. Hospital</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMAN IV.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/27/56</u>		<u>London PARK</u>		<u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Ruck</u>				ADDRESS <u>5305 Harford</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2572

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>51 Relay</u>	LENGTH OF STAY (in this place) <u>37 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1731 Magnolia Ave</u>		STREET ADDRESS (If rural give location) <u>1731 Magnolia Ave</u>	

3. NAME OF DECEASED: (First) <u>Charles Lewis</u> (Middle) <u>Kroll</u> (Last) <u>Kroll</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 4 1936</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb 2-1874</u>
9. AGE last birthday <u>82</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>German</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. R.R. Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John W. Kroll</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>706-09-1597</u>	
17. INFORMANT & ADDRESS: <u>Ed Kroll, (son) Relay 27 md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>177X Carcinoma of Prostate</u>	DUE TO	<u>5 yrs</u>
ANTECEDENT CAUSE (S) <u>Chor. Myocarditis</u>	DUE TO	<u>3 mos</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) <u>Disseminated</u>	<u>1 mo</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>		<u>5420</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1935, to Mar 4 1936, that I last saw the deceased alive on Mar 3, 1936, and that death occurred at 4A M., from the causes and on the date stated above.

SIGNATURE <u>Ed Kroll</u>	ADDRESS <u>3609 Main St</u>	DATE SIGNED <u>3/4/36</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>MAR. 7/36</u>	NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>
LOCATION (City, town, or county) (State) <u>DORSEY, M.D.</u>	DATE REC'D BY LOCAL REGISTRAR <u>3/5/36</u>	REGISTRAR'S SIGNATURE <u>AW [illegible]</u>
24. FUNERAL DIRECTOR <u>Harry H. Wyle</u>	ADDRESS <u>4101 EDMONDSON AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO THE SECRETARY OF THE INTERIOR  
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to the 1937 survey mentioned in the header.]

02587

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2600

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson Zone 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At Home</u>		STREET ADDRESS <u>910 Locustvale Road</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Katarzyna</u>		4. DATE OF DEATH <u>March 22nd 1956</u>	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/1/1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>POLAND</u>	
13. FATHER'S NAME <u>ANTONI KALATA</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SADOWSKI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>BERTHA HALLIDAY 910 LOCUSTVALE RD</u>	
16. SOCIAL SECURITY No.			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
332x Immediate cause (a) <u>Cerebral thrombosis</u>		<u>4 hrs</u>
Antecedent cause(s) (b) <u>Cerebral arteriosclerosis</u>		<u>4 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR 15, 1956, to MAR 22, 1956, that I last saw the deceased  
alive on MAR 15, 1956, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

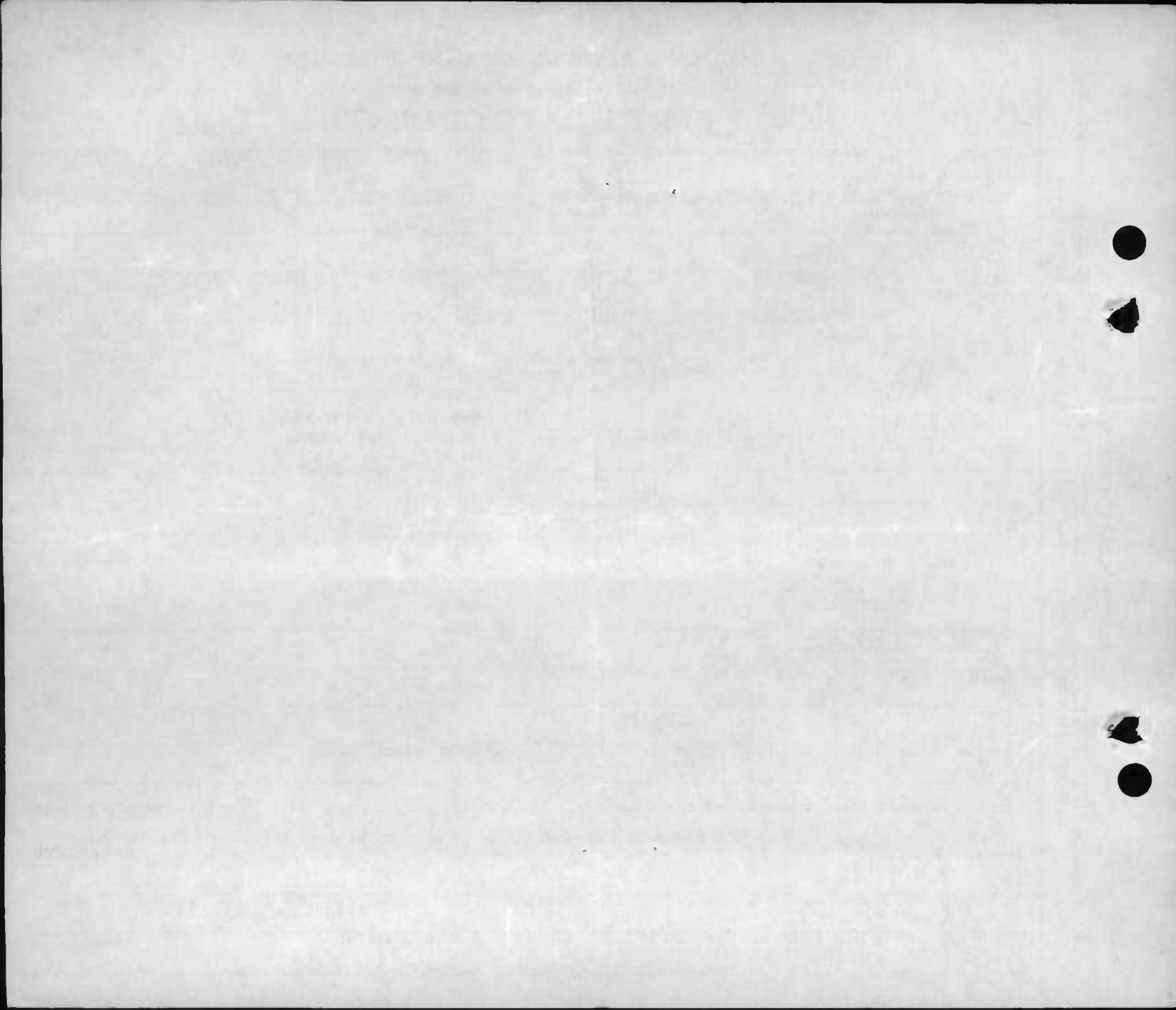
SIGNATURE Sidney J. Venable Jr MD ADDRESS 5808 7th Rd. Baltimore 12, Maryland DATE SIGNED MAR 23, 56  
(Degree or title)

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/26/56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	LOCATION (City, town, or county) <u>7535 German Hill Rd</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 24, 1956</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>George A. Weber</u>	ADDRESS <u>705 S. Ann St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2601 CERTIFICATE OF DEATH

02588

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Howard</i>		STATE <i>Md</i>		COUNTY <i>Balto City</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Catonville</i>		LENGTH OF STAY (in this place) <i>1 yr</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonville + Balto City</i>			
TOWN <i>Catonville</i>				STREET ADDRESS (If rural give location) <i>329 Harlem Ave #1322 Lower</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Caton Ridge Nursing Home</i>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>Catherine E Kunz</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>March 7 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Jan 29, 1868</i>	9. AGE last birthday <i>88</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wp. black</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Belgian saddle</i>		11. BIRTHPLACE (State or foreign country) <i>Balto</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Allen Kunz</i>				14. MOTHER'S MAIDEN NAME <i>Mary Beneman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS <i>Mrs Pearl L. McKinney</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
444X IMMEDIATE CAUSE (A) <i>Cardiac failure</i>		DUE TO				<i>3 weeks</i>	
ANTECEDENT CAUSE(S) (B) <i>1 1/2 years</i>		DUE TO				<i>unknown</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <i>Bed Sore peripheral edema</i>		DUE TO				<i>3 weeks</i>	
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>2/9/55</i> , to <i>3/7/56</i> , that I last saw the deceased alive on <i>2/29/55</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Carl Ernest J.</i>		ADDRESS (Street, city, town, state) <i>M.D. 4605 Edmondson ave</i>		DATE SIGNED <i>3/7/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>March 9/1956</i>		NAME OF CEMETERY OR CREMATORY <i>Louder Ph</i>		LOCATION (City, town, or county) <i>Balto</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>V.E. Harry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A. Howard Evans</i>		ADDRESS <i>1400 S Charles</i>	
DATE <i>MAR 8 1956</i>							

# CERTIFICATE OF DEATH

1900-1901

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BURIAL

9. NAME OF MINISTER

10. NAME OF WITNESSES

11. NAME OF PHYSICIAN

12. NAME OF CORONER

13. NAME OF JURY

14. NAME OF JURY

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BUREAU V. S.

MAR 8 1901

RECEIVED

2602

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Owings Mills</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lyons Mill Road</u>				d. STREET ADDRESS <u>Lyons Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Edward Lathe</u>				4. DATE OF DEATH Month Day Year <u>March 19 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1889</u>		9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher, retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Henery Lathe</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Virginia Harvey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Marie Sorg Brown, Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension +</u> DUE TO <u>arteriosclerosis</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3-16-56</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1-56</u> to <u>3-19-56</u> , that I last saw the deceased alive on <u>3-19-56</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Siffell</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown, Md. 3-20-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Paran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harrisonville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>				ADDRESS <u>Harrisonville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Mary Elving</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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PLATE 10

PLATE 1

BUREAU V. S.

MAR 21 1956

RECEIVED

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02590

2603 **CERTIFICATE OF DEATH**Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>1 mo</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51 Relay Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines</u>				STREET ADDRESS (If rural give location) <u>5920 Southwestern Blvd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Mary E. Lawrence</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>3 17 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1/25/1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Relay Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mr Wilfred A. Lawrence 5920 Southwestern Blvd</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <u>Hypertensive A. S. C.V.D.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Cerebral Hemorrhage</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>3/2</u> , 19 <u>53</u> , to <u>3/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John C. Healy M.D.</u>				ADDRESS (Street, city, town, state) <u>Natletowne 27, Md</u>			
DATE SIGNED <u>3/17/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto, National Cem.</u>		LOCATION (City, town, or county) (State) <u>5301 Frederick Ave</u>	
24. REC'D BY REGISTRAR <u>March 19, 1956</u>		REGISTRAR'S SIGNATURE <u>V.E. Larys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lowman &amp; Son</u>		ADDRESS <u>90 St.</u>	



MAR 20 1956

RECEIVED



2604

## CERTIFICATE OF DEATH

02591

Reg. Dist. No. 37

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. II institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Rd.</b>				d. STREET ADDRESS <b>York Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>May</b> Last <b>Lloyd</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-1870</b>	9. AGE (In years lost birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Brown</b>			
14. MOTHER'S MAIDEN NAME <b>Rebecca Myers</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>John A. Lloyd, Sparks, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial - chronic - degenerative</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute pneumonia - bronchial 4 weeks</b> DUE TO (c) <b>Hypertension + arteriosclerosis 3-yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-1-</b> , 19 <b>30</b> , to <b>3-28-56</b> , that I last saw the deceased alive on <b>3-26-56</b> , 19 <b>56</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James L. Saffell</b> M.D.				ADDRESS (Street, city or town, state) <b>Reisterstown, Md</b>			
PHYSICIAN'S NAME (Type) <b>James L. Saffell</b>				DATE SIGNED <b>3-28-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Falls Rd. Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>				ADDRESS <b>Sparks, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 30 March 56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara Annistead Mackie</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN W. SMITH		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1911		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Carpenter		RELIGION Roman Catholic		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DATE OF DEATH April 1, 1956		PLACE OF DEATH Home		RESIDENT OF Baltimore, Md.		DECEASED'S RESIDENCE 1234 Main St.		DECEASED'S OCCUPATION Carpenter		DECEASED'S RELIGION Roman Catholic	
DECEASED'S NAME JOHN W. SMITH		DECEASED'S AGE 45		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S DATE OF BIRTH 1911		DECEASED'S PLACE OF BIRTH Baltimore, Md.	
DECEASED'S MARRIAGE Married		DECEASED'S EDUCATION High School		DECEASED'S OCCUPATION Carpenter		DECEASED'S RELIGION Roman Catholic		DECEASED'S MANNER OF DEATH Natural		DECEASED'S CAUSE OF DEATH Heart Disease	
DECEASED'S DATE OF DEATH April 1, 1956		DECEASED'S PLACE OF DEATH Home		DECEASED'S RESIDENT OF Baltimore, Md.		DECEASED'S DECEASED'S RESIDENCE 1234 Main St.		DECEASED'S DECEASED'S OCCUPATION Carpenter		DECEASED'S DECEASED'S RELIGION Roman Catholic	

BUREAU V. S.

APR 2 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02592

2605

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u> COUNTY <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>Life</u>		TOWN <u>Catonsville</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>201 Garden Ridge Rd.</u>				STREET ADDRESS (If rural give location) <u>201 Garden Ridge Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Charles</u>		(Middle) <u>P.</u>		(Last) <u>Lupton</u>		<u>Mar. 25, 19 56</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 9, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Conductor</u>		10b. KIND OF WORK OR INDUSTRY <u>Balto. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Lupton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ridge Rd. Mr. Raymond B. Lupton, 201 Garden</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct. 13, 19 53</u> <b>to</b> <u>March 25, 19 56</u> <b>, that I last saw the deceased alive on</b> <u>March 25, 19 56</u> <b>and that death occurred at</b> <u>10:30 P.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>George A. Lupton</u> <b>M.D.</b> <u>4116 Edmondson Avenue</u> <b>DATE SIGNED</b> <u>Mar. 27, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEROF <u>Mar. 29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Lupton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wipke</u>		ADDRESS <u>4101 Edmondson Ave</u>	

DATE

MAR 28 1956

# CERTIFICATE OF DEATH

REG. GEN. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. DATE OF BIRTH

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. PLACE OF BIRTH

14. OCCUPATION

15. MARITAL STATUS

16. DATE OF BIRTH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. PLACE OF BIRTH

20. OCCUPATION

21. MARITAL STATUS

22. DATE OF BIRTH

23. PLACE OF DEATH

24. CAUSE OF DEATH

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. DATE OF BIRTH

29. PLACE OF DEATH

30. CAUSE OF DEATH

31. PLACE OF BIRTH

32. OCCUPATION

33. MARITAL STATUS

34. DATE OF BIRTH

35. PLACE OF DEATH

36. CAUSE OF DEATH

37. PLACE OF BIRTH

38. OCCUPATION

39. MARITAL STATUS

40. DATE OF BIRTH

41. PLACE OF DEATH

42. CAUSE OF DEATH

43. PLACE OF BIRTH

44. OCCUPATION

45. MARITAL STATUS

46. DATE OF BIRTH

47. PLACE OF DEATH

48. CAUSE OF DEATH

49. PLACE OF BIRTH

50. OCCUPATION

51. MARITAL STATUS

52. DATE OF BIRTH

53. PLACE OF DEATH

54. CAUSE OF DEATH

55. PLACE OF BIRTH

56. OCCUPATION

57. MARITAL STATUS

58. DATE OF BIRTH

59. PLACE OF DEATH

60. CAUSE OF DEATH

61. PLACE OF BIRTH

62. OCCUPATION

63. MARITAL STATUS

64. DATE OF BIRTH

65. PLACE OF DEATH

66. CAUSE OF DEATH

67. PLACE OF BIRTH

68. OCCUPATION

69. MARITAL STATUS

70. DATE OF BIRTH

71. PLACE OF DEATH

72. CAUSE OF DEATH

73. PLACE OF BIRTH

74. OCCUPATION

75. MARITAL STATUS

76. DATE OF BIRTH

77. PLACE OF DEATH

78. CAUSE OF DEATH

79. PLACE OF BIRTH

80. OCCUPATION

81. MARITAL STATUS

82. DATE OF BIRTH

83. PLACE OF DEATH

84. CAUSE OF DEATH

85. PLACE OF BIRTH

86. OCCUPATION

87. MARITAL STATUS

88. DATE OF BIRTH

89. PLACE OF DEATH

90. CAUSE OF DEATH

91. PLACE OF BIRTH

92. OCCUPATION

93. MARITAL STATUS

94. DATE OF BIRTH

95. PLACE OF DEATH

96. CAUSE OF DEATH

97. PLACE OF BIRTH

98. OCCUPATION

99. MARITAL STATUS

100. DATE OF BIRTH

101. PLACE OF DEATH

102. CAUSE OF DEATH

103. PLACE OF BIRTH

104. OCCUPATION

105. MARITAL STATUS

106. DATE OF BIRTH

107. PLACE OF DEATH

108. CAUSE OF DEATH

109. PLACE OF BIRTH

110. OCCUPATION

111. MARITAL STATUS

112. DATE OF BIRTH

113. PLACE OF DEATH

114. CAUSE OF DEATH

115. PLACE OF BIRTH

116. OCCUPATION

117. MARITAL STATUS

118. DATE OF BIRTH

119. PLACE OF DEATH

120. CAUSE OF DEATH

121. PLACE OF BIRTH

122. OCCUPATION

123. MARITAL STATUS

124. DATE OF BIRTH

125. PLACE OF DEATH

126. CAUSE OF DEATH

127. PLACE OF BIRTH

128. OCCUPATION

129. MARITAL STATUS

130. DATE OF BIRTH

131. PLACE OF DEATH

132. CAUSE OF DEATH

133. PLACE OF BIRTH

134. OCCUPATION

135. MARITAL STATUS

136. DATE OF BIRTH

137. PLACE OF DEATH

138. CAUSE OF DEATH

139. PLACE OF BIRTH

140. OCCUPATION

141. MARITAL STATUS

142. DATE OF BIRTH

143. PLACE OF DEATH

144. CAUSE OF DEATH

145. PLACE OF BIRTH

146. OCCUPATION

147. MARITAL STATUS

148. DATE OF BIRTH

149. PLACE OF DEATH

150. CAUSE OF DEATH

151. PLACE OF BIRTH

152. OCCUPATION

153. MARITAL STATUS

154. DATE OF BIRTH

155. PLACE OF DEATH

156. CAUSE OF DEATH

157. PLACE OF BIRTH

158. OCCUPATION

159. MARITAL STATUS

160. DATE OF BIRTH

161. PLACE OF DEATH

162. CAUSE OF DEATH

163. PLACE OF BIRTH

164. OCCUPATION

165. MARITAL STATUS

166. DATE OF BIRTH

167. PLACE OF DEATH

168. CAUSE OF DEATH

INSTRUCTIONS

1. The purpose of this form is to provide a uniform method of recording the facts of death and to provide a basis for the collection of statistics on the causes of death and the conditions of death.

2. The information on this form should be obtained from the medical attendant, the coroner, or the person who has the best knowledge of the facts of the death.

3. The information on this form should be filled out as completely and accurately as possible.

4. The information on this form should be filled out in ink.

5. The information on this form should be filled out in the English language.

6. The information on this form should be filled out in the following order:

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Place of birth
8. Occupation
9. Marital status
10. Date of birth
11. Place of death
12. Cause of death
13. Place of birth
14. Occupation
15. Marital status
16. Date of birth
17. Place of death
18. Cause of death
19. Place of birth
20. Occupation
21. Marital status
22. Date of birth
23. Place of death
24. Cause of death
25. Place of birth
26. Occupation
27. Marital status
28. Date of birth
29. Place of death
30. Cause of death
31. Place of birth
32. Occupation
33. Marital status
34. Date of birth
35. Place of death
36. Cause of death
37. Place of birth
38. Occupation
39. Marital status
40. Date of birth
41. Place of death
42. Cause of death
43. Place of birth
44. Occupation
45. Marital status
46. Date of birth
47. Place of death
48. Cause of death
49. Place of birth
50. Occupation
51. Marital status
52. Date of birth
53. Place of death
54. Cause of death
55. Place of birth
56. Occupation
57. Marital status
58. Date of birth
59. Place of death
60. Cause of death
61. Place of birth
62. Occupation
63. Marital status
64. Date of birth
65. Place of death
66. Cause of death
67. Place of birth
68. Occupation
69. Marital status
70. Date of birth
71. Place of death
72. Cause of death
73. Place of birth
74. Occupation
75. Marital status
76. Date of birth
77. Place of death
78. Cause of death
79. Place of birth
80. Occupation
81. Marital status
82. Date of birth
83. Place of death
84. Cause of death
85. Place of birth
86. Occupation
87. Marital status
88. Date of birth
89. Place of death
90. Cause of death
91. Place of birth
92. Occupation
93. Marital status
94. Date of birth
95. Place of death
96. Cause of death
97. Place of birth
98. Occupation
99. Marital status
100. Date of birth

BUREAU V. S.

MAR 28 1956

RECEIVED

## 2606 CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 CATONSVILLE</b>	LENGTH OF STAY (in this place) <b>1 month</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Spanows Point</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>14 Spring Grove St. Hosp.</b>		STREET ADDRESS (If rural give location) <b>2614 Massett Ave.</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <b>John</b>	(Middle) <b>E.</b>	(Last) <b>LYDIC</b>	(Month) <b>3</b> (Day) <b>3</b> (Year) <b>1956</b>
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>sep.</b>	8. DATE OF BIRTH: <b>12-25-1879</b>
9. AGE last birthday: <b>76</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>—</b>	11. BIRTHPLACE (State or foreign country): <b>Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME: <b>Jacob Lydic</b>	
14. MOTHER'S MAIDEN NAME: <b>Wardline Bouch</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>—</b> (If Yes, give war or dates of service) <b>—</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT & ADDRESS: <b>Hospital record</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Uremia</b>			
ANTECEDENT CAUSE (B) <b>Cerebral Thrombosis (Right)</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>Generalized Atherosclerosis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/2</b> , 1956, to <b>3/3</b> , 1956, that I last saw the deceased alive on <b>3/3</b> , 1956, and that death occurred at <b>11:00</b> P.M., from the causes and on the date stated above.			
SIGNATURE <b>J. Brown</b>		ADDRESS <b>Spring Grove Hosp.</b> DATE SIGNED <b>3/3/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>REMOVAL</b>	<b>MAR 4, 1956</b>	<b>TAYLORSVILLE CEM</b>	<b>HILLSDALE PA</b>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>MAR 5 - 1956</b>	<b>J. Brown</b>	<b>MULLRICH FUNERAL HOME</b>	<b>DUNDALK.</b>

MARGIN RESERVED FOR BINDING



BUREAU V. S.

MAR 8 1956

RECEIVED



2607

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr 1mo. 4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roderick</b> Middle <b>Hanson</b> Last <b>MacKenzie</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1908</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Navigation Specialist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
13. FATHER'S NAME <b>William Allen MacKenzie</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pyonephrosis</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonism due to Hypertensive CVA</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 15</b> , 19 <b>55</b> , to <b>March 19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 19</b> , 19 <b>56</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Louie Frances Woodward</b> M.D. <b>Spring Grove State Hospital, Catonsville, Md. 3-19-56</b>							
ACTUAL SIGNATURE <b>Louie Frances Woodward</b> PHYSICIAN'S NAME (Type) <b>Louie Frances Woodward</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>March 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Jasshi Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3/23/56</b>		24b. REGISTRAR'S SIGNATURE <b>V. C. Harry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1956

RECEIVED

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
JAMES EARL RAY		APRIL 22, 1928	
SEX		RACE	
MALE		WHITE	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
OCCUPATION		PLACE OF BIRTH	
CLOCK REPAIRER		MEMPHIS, TENNESSEE	
DATE OF DEATH		PLACE OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH	
10:00 PM		HEART DISEASE	
DATE OF BURIAL		PLACE OF BURIAL	
APRIL 10, 1968		MEMPHIS, TENNESSEE	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES EARL RAY FUNERAL HOME		JAMES EARL RAY	
ADDRESS OF DECEASED		ADDRESS OF FUNERAL HOME	
1000 N. 1ST ST.		1000 N. 1ST ST.	
CITY		STATE	
MEMPHIS		TENNESSEE	
COUNTY		ZIP CODE	
SHELBY		38102	
DATE OF CERTIFICATE		SIGNATURE OF REGISTRAR	
APRIL 10, 1968		JAMES EARL RAY	
OFFICE		TITLE	
MEMPHIS		REGISTERAR	
COUNTY		STATE	
SHELBY		TENNESSEE	
ZIP CODE		DATE OF CERTIFICATE	
38102		APRIL 10, 1968	

2678  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1 mo, 23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Simon</b> Middle <b>Marget</b> Last <b>March</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensatory Heart Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Myocardial Degeneration</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-29</b> , 19 <b>56</b> , to <b>3-23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3-23</b> , 19 <b>56</b> , and that death occurred at <b>11:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Isadore Tuerk, M.D.</b>				ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b>		DATE SIGNED <b>3-23-56</b>	
PHYSICIAN'S NAME (Type) <b>Isadore Tuerk, M.D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mickro Kodesh, Herring Run</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>SOL LEVINSON &amp; BROS INC 1124-26 W. North Ave</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>V. E. Harrys</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
MAY 19 1956		BALTIMORE, MARYLAND	
HABIT		OCCUPATION	
WHITE		LABORER	
AGE		SEX	
38		MALE	
DATE OF BIRTH		PLACE OF BIRTH	
MAY 18 1918		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
CORONARY THROMBOSIS		HYPERTENSION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNS AND SYMPTOMS		POSTMORTEM EXAMINATION	
PAIN IN CHEST		NO	
DYSNOEA		NO	
FATIGUE		NO	
LOSS OF APPETITE		NO	
WEIGHT LOSS		NO	
BLOOD PRESSURE		BLOOD PRESSURE	
160/100		160/100	
HEART RATE		HEART RATE	
100		100	
TEMPERATURE		TEMPERATURE	
100.0		100.0	
PULSE		PULSE	
90		90	
RESPIRATION		RESPIRATION	
20		20	
OXYGEN SATURATION		OXYGEN SATURATION	
95%		95%	
SMOKING HABIT		ALCOHOLIC HABIT	
SMOKES		NONE	
TYPICAL OF DEATH		TYPICAL OF DEATH	
YES		YES	
UNUSUAL		UNUSUAL	
NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. SMITH		J. H. SMITH	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 19 1956		MAY 19 1956	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
HABIT		OCCUPATION	
WHITE		LABORER	
AGE		SEX	
38		MALE	
DATE OF BIRTH		PLACE OF BIRTH	
MAY 18 1918		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
CORONARY THROMBOSIS		HYPERTENSION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNS AND SYMPTOMS		POSTMORTEM EXAMINATION	
PAIN IN CHEST		NO	
DYSNOEA		NO	
FATIGUE		NO	
LOSS OF APPETITE		NO	
WEIGHT LOSS		NO	
BLOOD PRESSURE		BLOOD PRESSURE	
160/100		160/100	
HEART RATE		HEART RATE	
100		100	
TEMPERATURE		TEMPERATURE	
100.0		100.0	
PULSE		PULSE	
90		90	
RESPIRATION		RESPIRATION	
20		20	
OXYGEN SATURATION		OXYGEN SATURATION	
95%		95%	
SMOKING HABIT		ALCOHOLIC HABIT	
SMOKES		NONE	
TYPICAL OF DEATH		TYPICAL OF DEATH	
YES		YES	
UNUSUAL		UNUSUAL	
NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. SMITH		J. H. SMITH	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 19 1956		MAY 19 1956	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. S.

MAR 27 1956

RECEIVED

# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G10, 3-29-56 et

2609

## CERTIFICATE OF DEATH

02596

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>128</u> days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>BALTO.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">(21)</span> d. STREET ADDRESS <u>38 Glenwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROBERT</u> Middle <u>A.</u> Last <u>MARKLE</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>24</u> Year <u>1956</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/30/09</u>		<b>9. AGE</b> (In years last birthday) <u>46</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Medical Research Technician U.S. Government</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Government</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Fork, California</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Alexander R. Markle</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Rutha Mae Patton</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-18-1409</u>		<b>17. INFORMANT</b> <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE LEUKEMIA</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that</b> <u>VA</u> attended the deceased from <u>November 16, 1955</u> , to <u>March 24, 1956</u> , <u>mark that saw the deceased</u> <u>alive on</u> <u>12-27-55</u> and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>3/24/56</u> ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M. D.</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3/27/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Alfred Burke Bradley, Landolt, Md</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>27 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Dawson L. Lasker</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1956

RECEIVED  
MAR 27 1956



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2610

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

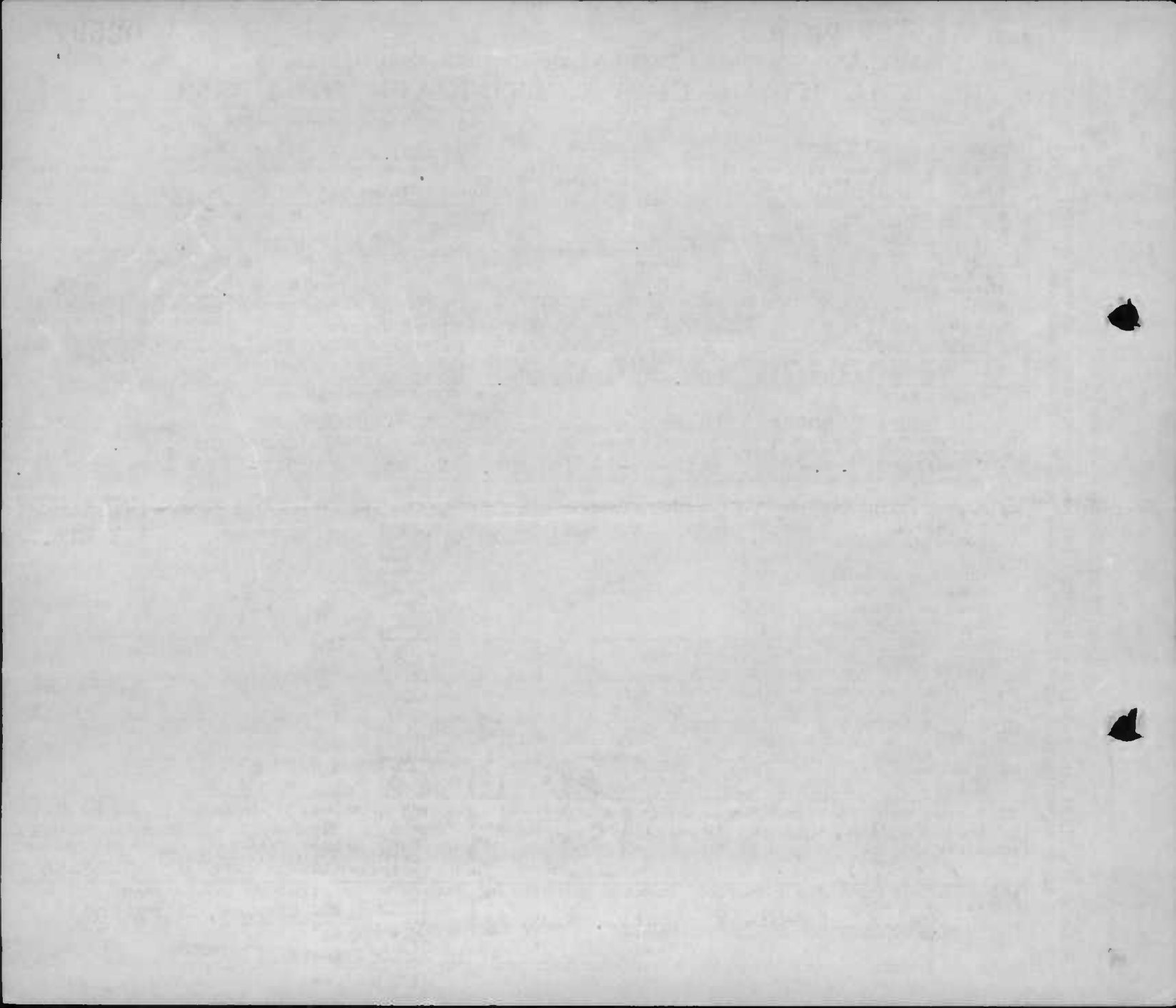
02597

Reg. Dist.

No. 31

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockdale</u>		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rockdale</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3623 Langrehr Rd.</u>			STREET ADDRESS (If rural, give location) <u>3623 Langrehr Rd.</u>		
3. NAME OF DECEASED: (Type or Print) <u>BERNARD</u> <u>C.</u> <u>MARTIN</u>			4. DATE OF DEATH <u>Mar.</u> <u>18</u> <u>19</u> <u>56</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>May 5, 1918</u>		9. AGE last birthday: <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Industrial Eng.-Radiator Mfg</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Ohio</u>	11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Bernard Cheston Goldberg</u>			14. MOTHER'S MAIDEN NAME: <u>Nettie S. Conwell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> <input checked="" type="checkbox"/> (If Yes, give war or dates of service) <u>W.W.#2</u>		16. SOCIAL SECURITY No.: <u>218-05-0451</u>	17. INFORMANT & ADDRESS: <u>Rockdale, Md.</u> <u>Mrs. Stefania Martin-3623 Langrehr Rd.</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				5 min.	
<u>430.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>					
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>none</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>D.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>3-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Wm. J. Tibbels &amp; Sons Balto.</u>			
DATE REC'D BY LOCAL REG. <u>3-20-56</u>		REGISTRAR'S SIGNATURE <u>17, Md.</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02598
Item 20 Film G194 8-27-56 ans										
2611 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Bethlehem Steel Co. Dispensary</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> (28)			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Dispensary</u>					d. STREET ADDRESS <u>218 Shadynook Ct.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas E. Martin</u>					4. DATE OF DEATH Month Day Year <u>3-15-56</u> 19					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-1938</u>		9. AGE (In years last birthday) <u>17</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oiler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apprentice Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Thomas B. Martin</u>					14. MOTHER'S MAIDEN NAME <u>Virginia E. Wilcox</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-36-4730</u>		17. INFORMANT Address <u>Thomas B. Martin 218 Shadynook Ct. (28)</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury to chest.</u> <u>912.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>NONE</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught between body &amp; frame of crane</u>							
20c. TIME OF INJURY Hour <u>8:40</u> p. m. <u>3-15</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Steel Plant</u>		20f. (City or town) <u>Sparrows Point</u>		(County) <u>Balto</u> (State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>M. B. Davis</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>			22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Howard Strong</u>					ADDRESS <u>3207 W. North Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>	

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
MARITAL STATUS [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	

RECEIVED  
 MAR 19 1956  
 BUREAU V. S.

RECEIVED  
 MAR 19 1956  
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallston</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallston</u>		d. STREET ADDRESS <u>Megan &amp; off Holt Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>55 Main &amp; off Holt Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Selma Anna Martign</u>				4. DATE OF DEATH Month Day Year <u>Mar 4 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 18 78</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Brown</u>				14. MOTHER'S MAIDEN NAME <u>Anna Marie Martign</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hubert H Martign</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO (b) <u>cardiovascular</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19 56</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Les M Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Les M Kieffer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Mar 5 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 6 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Randallston Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H Newell</u>				ADDRESS <u>Parkville</u>		24a. REC'D BY REGISTRAR DATE <u>6 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martign</u>

3015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: *John H. Smith*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *March 5, 1936*  
5. Place of death: *Home*  
6. Cause of death: *Heart failure*  
7. Manner of death: *Natural*  
8. Signature of medical examiner: *John H. Smith*  
9. Signature of physician: *John H. Smith*  
10. Signature of coroner: *John H. Smith*

BUREAU V. S.

MAR 6 1936

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

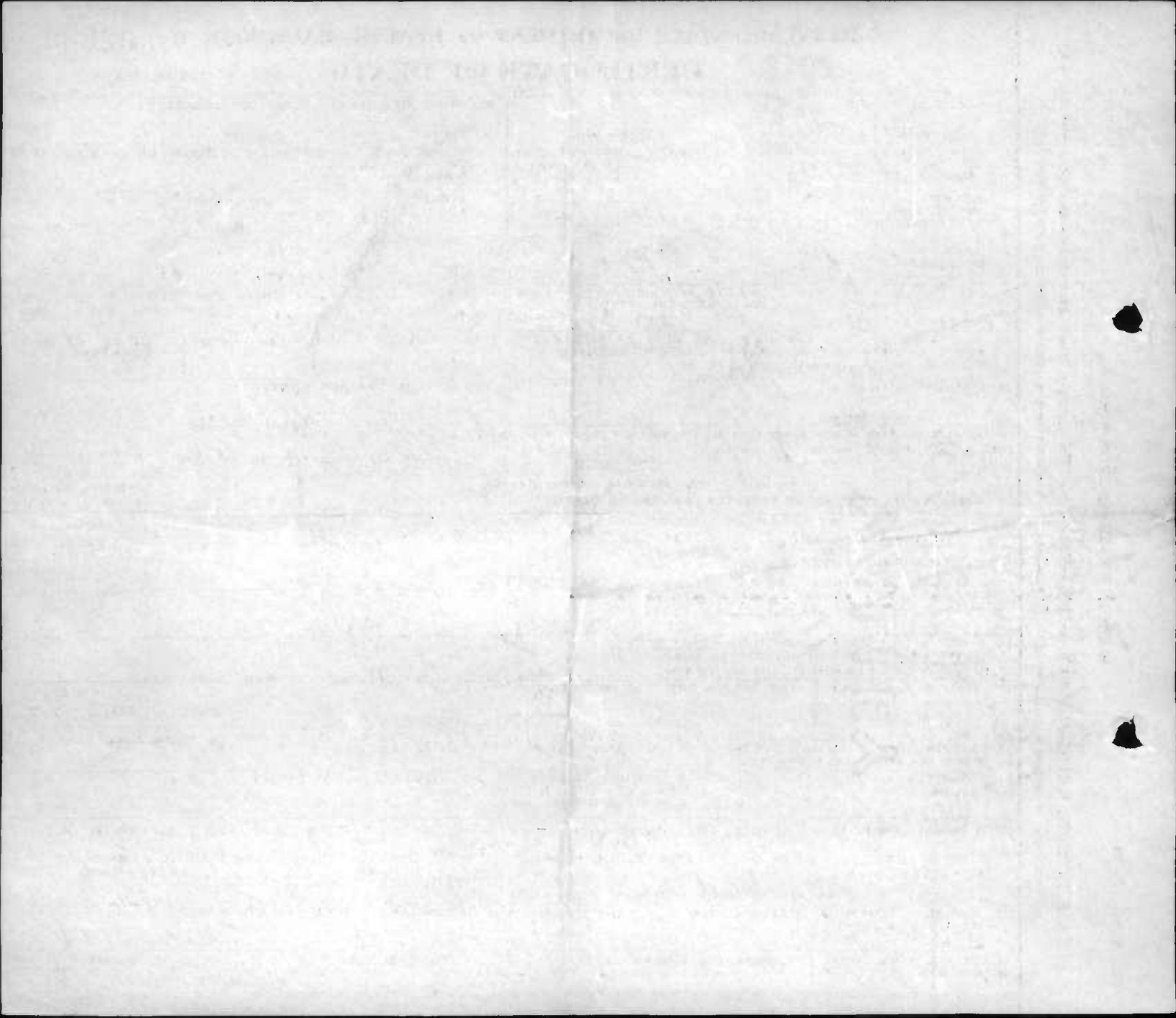
02600

2613

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
TOWN <u>Catonsville</u>		<u>3yr 4mos 17 days</u>		STREET ADDRESS (If rural give location) <u>2647 Dulaney Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Sabina Agnes McCormack</u>				<u>March 2, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>9-23-1889</u>	<u>66</u> yrs	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>DOMESTIC</u>		<u>Ireland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Ward</u>				<u>Mary McDERMOTT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>Unknown</u>		<u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerosis, generalized</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Dehydration</u>							
(C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-</u> , 19 <u>53</u> , to <u>3-2-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-2-</u> , 19 <u>56</u> , and that death occurred at <u>12:15 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Sheila Wachler</u>				DATE SIGNED <u>3-2-56</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-5-56</u>		<u>NEW CATHEDRAL</u>		<u>BALTIMORE Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 3, 1956</u>		<u>L.W.</u>		<u>George L. Schwal</u>		<u>Baltimore Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02601

2614

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6822 Dogwood Rd.</u>		STREET ADDRESS (If rural, give location) <u>6822 Dogwood Road</u>	
3. NAME OF DECEASED (First) <u>Emma H.</u> (Middle) <u>Meekins</u> (Last)	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>11</u> (Year) <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 12, 1894</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>11</u> Hours <u>19</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
12. BIRTHPLACE (State or foreign country) <u>Balto. md.</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. FATHER'S NAME <u>Louis Frank</u>		15. MOTHER'S MAIDEN NAME <u>Margrethe Stump</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>no</u>	
18. INFORMANT <u>Mr. Albert J. Meekins - 6822 Dogwood Rd. 7</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>	<u>36 hours</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>	<u>4 years</u>
(c)	

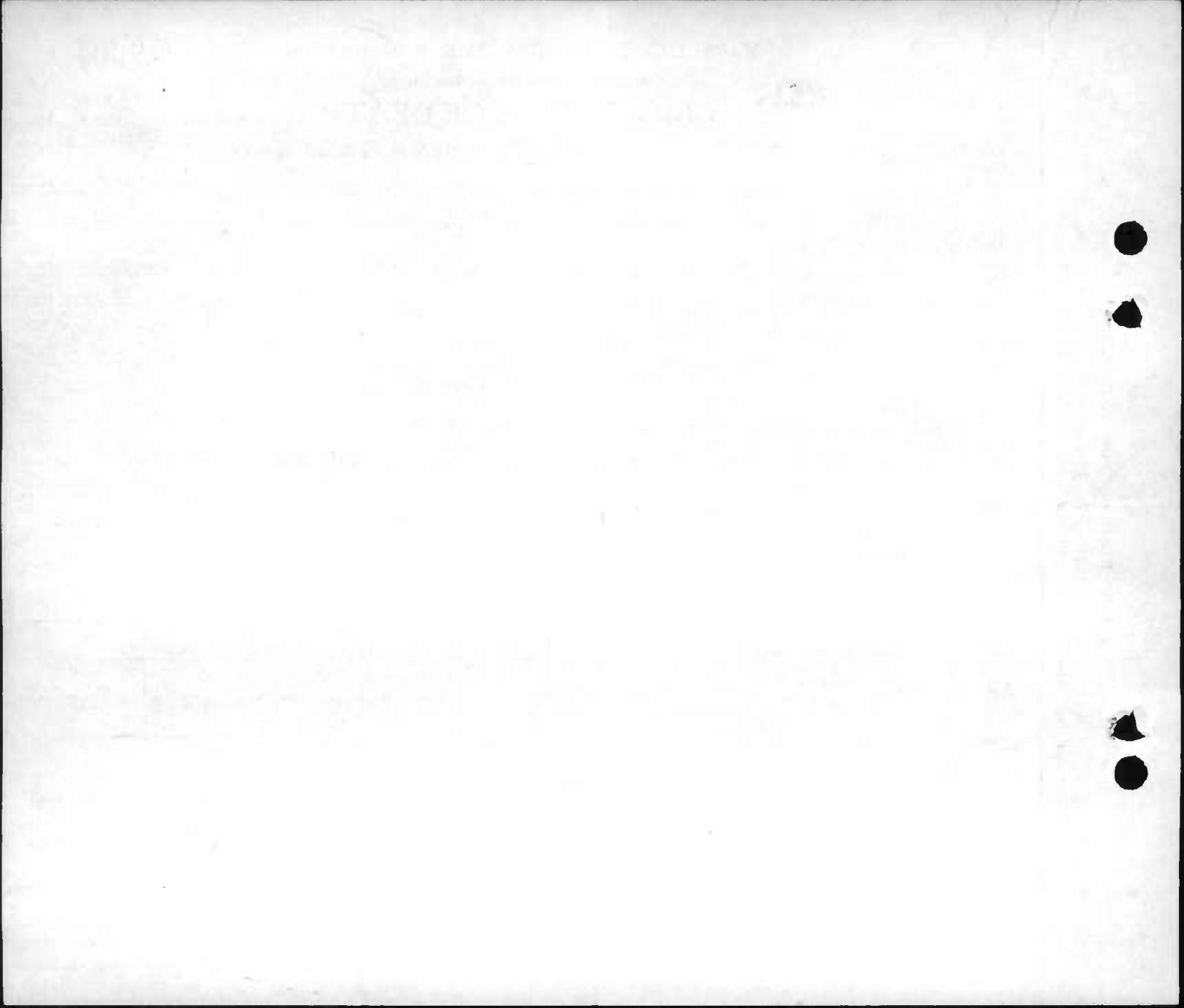
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>no operation</u>	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 16, 1949, to Mar. 11, 1956, that I last saw the deceased alive on Mar. 11, 1956, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE <u>Joshua H. Armacost M.D.</u>	ADDRESS <u>6419 Windsor Mill Rd Baltimore 7 Md.</u>	DATE SIGNED <u>3-12-56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/14/56</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>
LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>md.</u>	
DATE REC'D BY LOCAL REG. <u>3-13-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John T. Stansbury</u>
		ADDRESS <u>6411 Windsor Mill Rd. 7</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02602

2615 **CERTIFICATE OF DEATH**Reg. Dist. No. **33**

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAMPSTEAD Rural</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAMPSTEAD Rural</u>			
HOSPITAL OR INSTITUTION STREET ADDRESS <u>Black Rock Road</u>				STREET ADDRESS (If rural give location) <u>Black Rock Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Bessie</u> (First) <u>Estella</u> (Middle) <u>Merryman</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>9</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Oct 15, 1893</u>	<b>9. AGE last birthday</b> <u>62</u> Yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Irvin S. Leister</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lena B. Neudecker</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>John E. Merryman; Hampstead Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>430.1 IMMEDIATE CAUSE</b> (A) <u>Acute Coronary Occlusion</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Suddenly</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Coronary Heart Disease</u>						<u>Several years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>Hypertensive Cardio-Vascular Disease</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>M.</u> <u>at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>JAN 4</u> , 19 <u>48</u> , to <u>March 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P</u> .M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Joseph E. Bush</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Hampstead Md</u>		<b>DATE SIGNED</b> <u>March 9, 1956</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-12-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Grave Meth.</u>		<b>LOCATION</b> (City, town, or county) <b>(State)</b> <u>Balto co Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary B. Stone</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Eduard C. Tipton</u>		<b>ADDRESS</b> <u>Hampstead Md</u>	
<b>DATE</b> <u>3-10-56</u>							

BUREAU V. S.

MAR 13 1956

RECEIVED

3-10-28 11:50 AM 2.9



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2616 CERTIFICATE OF DEATH

02603

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Towson</u>		<u>6 mon.</u>		TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 York Road</u>				STREET ADDRESS (If rural give location) <u>420 York Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>EMILIJA</u> (Middle) <u>MEZGALS</u> (Last)				(Month) <u>March</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>May 29, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? (DP)	
<u>Housewife</u>		<u>Own Home</u>		<u>Latvia</u>		<u>USA</u> ( <u>DP</u> )	
13. FATHER'S NAME <u>Christoph Privert</u>				14. MOTHER'S MAIDEN NAME <u>Louisa ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>U.S. Govt. D.P. Papers</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Hypertensive cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/9/1954</u> , to <u>3/16/1956</u> , that I last saw the deceased alive on <u>3/11/1956</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Amundson</u>		ADDRESS (Street, city, town, state) <u>3800 Erdman Ave, #13</u>		DATE SIGNED <u>3/16/1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 15 1956</u>		REGISTRAR'S SIGNATURE <u>Mehl Grays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Maryland</u>	

05613

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

Birth Date: 1891

DEATH CERTIFICATE NUMBER: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

UNDERLYING CAUSE OF DEATH: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

UNDERLYING CAUSE OF DEATH: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

UNDERLYING CAUSE OF DEATH: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

UNDERLYING CAUSE OF DEATH: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

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UNDERLYING CAUSE OF DEATH: 10000000000000000000

DATE OF DEATH: 1956

PLACE OF DEATH: 10000000000000000000

CAUSE OF DEATH: 10000000000000000000

IMMEDIATE CAUSE OF DEATH: 10000000000000000000

UNDERLYING CAUSE OF DEATH: 10000000000000000000

BUREAU V. S.

MAR 19 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02604

2617

## CERTIFICATE OF DEATH

Reg. Dist. No.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print) <i>MILES CLARENCE</i>			2. DATE OF DEATH <i>3/24/56</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Catonsville Md.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Catons Ridge Nursing Home</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>(NA)</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widower</i>	8. DATE OF BIRTH <i>9-27-1867</i>	9. AGE (In years last birthday) <i>88</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			11. BIRTHPLACE (State or foreign country) <i>Sparks Maryland</i>	
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>John Buck Miles</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Marks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>214-01344</i>	
17. INFORMANT <i>Mrs. E. C. Burings</i>			ADDRESS <i>6027 Bellvue Ave</i>	
18. <i>450.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hyostatic pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>As two severe chronic</i>			<i>6 Bed Sore</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Aged</i>				
19A. DATE OF OPERATION <i>March 23, 1956</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>As two severe chronic</i>	
20. TIME OF INJURY (Day) (Year) (Hour) <i>10:30 P.M.</i>			21. HOW DID INJURY OCCUR? <i>As two severe chronic</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>March 23, 1956</i> to <i>March 23, 1956</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>Edith K. Smith</i>			23B. ADDRESS <i>4605 Edmond Ave</i>	
23C. DATE SIGNED <i>3/28/56</i>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>March 31, 1956</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mount Carmel Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25. FUNERAL DIRECTOR <i>Edmund O. Smith</i>			ADDRESS <i>4605 Edmond Ave</i>	

02007

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02605

2618

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

Items 11, 12 Film 0195 4-6-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
CITY <u>Balto.</u>		STATE <u>Md.</u>		COUNTY <u>Ba</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lutherville, Md.</u>				TOWN <u>Baltimore</u>		3701.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>				STREET ADDRESS (If rural give location) <u>4 Chancery Square</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>HENRIETTA STEVENS MILLS</u>				<u>Mar. 26, 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>female</u>	<u>white</u>	<u>married</u>	<u>Sept. 9, 1888</u>	<u>67</u>	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>at home</u>		<u>Unknown Baltimore, Md.</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>unknown Stevens</u>				<u>Carrie Hurlock</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>Mr. Rowland V. Mills-4 Chancery Square</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>334X IMMEDIATE CAUSE (A)</b>				<u>Cerebral Art. Sclerosis - Cerebral Softening</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>				<u>Old Hemiplegia</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<u>Obesity - Hypertension</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Carcinoma - Colon?</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Initial 4/55</u> to <u>Mar 26 1956</u>, that I last saw the deceased alive on <u>Mar 25, 1956</u>, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE</b>		<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Walter A. Baetjer</u>		<u>3/29/56</u>		<u>1001 55th Ave SE</u>		<u>Bethesda Md</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>3/29/56</u>		<u>Druid Ridge Cem.</u>		<u>Pikesville, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>MAR 28 1956</u>		<u>Anne MacRae</u>		<u>Wm. J. Tolaney &amp; Sons - Balto</u>		<u>17</u>	

# CERTIFICATE OF DEATH

FILE NO. 11

A. UNDER REGISTRATION (HOUSE OR OUTDOOR)

PLACE OF DEATH

NAME

SEX AND AGE

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IN MEDICAL CERTIFICATION

BUREAU Y. 8

MAR 29 1956

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2619  
CERTIFICATE OF DEATH

02606  
40

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hydes Md</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Regwood Rd</u>		d. STREET ADDRESS <u>REGWOOD ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Frank William Monnin</u>		4. DATE OF DEATH <u>March 28 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 17, 1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEET METAL LAYOUT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK STATE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK William Monnin</u>		14. MOTHER'S MAIDEN NAME <u>MARY THIEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-2865</u>	
17. INFORMANT <u>Norah W. Monnin</u>		Address <u>Regwood Rd. Hydes, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatitis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Pancreas</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>1 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>March 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 28</u> , 19 <u>56</u> , and that death occurred at <u>9:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>3-29-56</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>4401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>April 2, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL RECORDS  
 CERTIFICATE OF DEATH

NAME OF DECEASED <i>John A. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1911</i>		PLACE OF BIRTH <i>New York City</i>	
FATHER'S NAME <i>John A. Smith</i>		MOTHER'S NAME <i>Mary E. Smith</i>		MARRIAGE DATE <i>Jan 15 1911</i>		MARRIAGE PLACE <i>New York City</i>		MARRIAGE REGISTERED <input checked="" type="checkbox"/>		MARRIAGE LICENSE NO. <i>12345</i>	
DECEASED'S RESIDENCE <i>123 Main St, New York City</i>		DECEASED'S OCCUPATION <i>Teacher</i>		DECEASED'S STATUS <i>Married</i>		DECEASED'S RELIGION <i>Catholic</i>		DECEASED'S EDUCATION <i>High School</i>		DECEASED'S SERVICE <i>None</i>	
DECEASED'S SOCIAL SECURITY NO. <i>123-45-6789</i>		DECEASED'S VOTER REGISTRATION <i>None</i>		DECEASED'S MILITARY SERVICE <i>None</i>		DECEASED'S NAVY SERVICE <i>None</i>		DECEASED'S AIR FORCE SERVICE <i>None</i>		DECEASED'S MARINE SERVICE <i>None</i>	
DECEASED'S DEATH DATE <i>Apr 2 1956</i>		DECEASED'S DEATH TIME <i>10:00 AM</i>		DECEASED'S DEATH PLACE <i>New York City</i>		DECEASED'S DEATH CAUSE <i>Heart Disease</i>		DECEASED'S DEATH MANNER <i>Natural</i>		DECEASED'S DEATH CERTIFICATE NO. <i>12345</i>	
DECEASED'S DEATH CERTIFICATE NO. <i>12345</i>		DECEASED'S DEATH CERTIFICATE DATE <i>Apr 2 1956</i>		DECEASED'S DEATH CERTIFICATE TIME <i>10:00 AM</i>		DECEASED'S DEATH CERTIFICATE PLACE <i>New York City</i>		DECEASED'S DEATH CERTIFICATE CAUSE <i>Heart Disease</i>		DECEASED'S DEATH CERTIFICATE MANNER <i>Natural</i>	
DECEASED'S DEATH CERTIFICATE TIME <i>10:00 AM</i>		DECEASED'S DEATH CERTIFICATE PLACE <i>New York City</i>		DECEASED'S DEATH CERTIFICATE CAUSE <i>Heart Disease</i>		DECEASED'S DEATH CERTIFICATE MANNER <i>Natural</i>		DECEASED'S DEATH CERTIFICATE NO. <i>12345</i>		DECEASED'S DEATH CERTIFICATE DATE <i>Apr 2 1956</i>	
DECEASED'S DEATH CERTIFICATE NO. <i>12345</i>		DECEASED'S DEATH CERTIFICATE DATE <i>Apr 2 1956</i>		DECEASED'S DEATH CERTIFICATE TIME <i>10:00 AM</i>		DECEASED'S DEATH CERTIFICATE PLACE <i>New York City</i>		DECEASED'S DEATH CERTIFICATE CAUSE <i>Heart Disease</i>		DECEASED'S DEATH CERTIFICATE MANNER <i>Natural</i>	

**RECEIVED**  
 APR 2 1956  
 BUREAU V. 81

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02607

## 2620 CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>X</i> <i>Kedewood</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <i>X</i> <i>Kedewood</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1725 W. Joppa Road</i>				STREET ADDRESS (If rural give location) <i>1723 W Joppa Road</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Lina</i> (First) <i>H.</i> (Middle) <i>Morris</i> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Mar 7 - 1956</i>			
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>Apr 11-1877</i>	9. AGE last birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Fredericks Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Ephraim B Morris</i>				14. MOTHER'S MAIDEN NAME <i>L Susan C. Frim</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Walter L. Cox 1725 W Joppa Rd</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <i>Cerebral Haemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/6/1956</i> , to <i>3/7/1956</i> , that I last saw the deceased alive on <i>3/7/1956</i> , and that death occurred at <i>9:43 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>M. X. Quinn</i>				DATE SIGNED <i>3/8/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar 10 1956</i>		NAME OF CEMETERY OR CREMATORY <i>MT Zion</i>		LOCATION (City, town, or county) <i>Fredericks Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mabel C. Gray</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns</i>		ADDRESS <i>Box 4</i>	
DATE <i>March 9, 1956</i>							

100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

# DEATH CERTIFICATE

Form No. 1

REGISTRATION DIVISION OF DEATHS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

SIBLINGS

ANCESTORS

DESCENDANTS

COUSINS

UNCLES

AUNT

NEPHEWS

GRANDNIECES

OTHER

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

SIBLINGS

ANCESTORS

DESCENDANTS

COUSINS

UNCLES

AUNT

NEPHEWS

GRANDNIECES

OTHER

REMARKS

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CAUSE

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SEX

RACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must jointly fill in by the funeral director. After the certificate has been signed by the attending physician and coroner, it must be filed with the funeral director. After the certificate has been filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2621

## CERTIFICATE OF DEATH

Reg. Dist. No.

02608

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> 3401.4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>		d. STREET ADDRESS <u>1523 W. Pratt St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>26</u> Year <u>19 56</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Miss Patricia Murphy, 1523 W. Pratt St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1956</u> to <u>March 26, 1956</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>56</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P.D. Hyman</u> M.D. <u>11 E. Chase St</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>3/27/56</u>			
PHYSICIAN'S NAME (Type) <u>P.D. Hyman</u>		<u>Baltimore 2, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Balto. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wible</u> ADDRESS <u>4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR DATE <u>28 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MAYLAND		25		F		W		1910		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF DEATH		PLACE OF DEATH	
Nurse		High School		Married		Catholic		1935		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF ONSET		DATE OF EXAMINATION		PLACE OF EXAMINATION	
Tuberculosis		Natural		6 months		1934		1935		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
J. H. Smith		A. B. Jones		M. K. Lee		W. R. Brown		C. D. Green		E. F. White	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1935		1935		1935		1935		1935		1935	

BUREAU V. S.

MAR 28 1935

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02609

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville 28</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Spring Grove State Hospital</u>				d. STREET ADDRESS <u>327 N. Calhoun Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Caroline</u> <u>NMI</u> <u>Myers</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March</u> <u>17</u> <u>19 56</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>unknown</u>			
<b>9. AGE</b> (In years last birthday) <u>over 70</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Music teacher</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Charles F. Myers</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Augusta W. Perchan</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Records: Spring Grove State Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Geo. M. Kieffer</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>Mar 17 56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Geo. M. Kieffer</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>MAR 22 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>LOU DON PARK CEM</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>FREDERICK RD MD</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 22 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>V. E. Harry</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Duffel Brothers 1800 E Lombard St</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 22 1936

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02610

## 2623 CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>290 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		<u>028-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #2 Box 128-A</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES</u> (First) <u>MYERS</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 2, 1882</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier- Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Myers</u>				14. MOTHER'S MAIDEN NAME <u>Alice Devine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS WITH LEFT HEMIPLEGIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Hour) (Minute) <u>VA</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 16</u> , 19 <u>55</u> , to <u>March 1</u> , 19 <u>56</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. G. Dickey</u>		ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>3/2/56</u>			
F. G. DICKEY, M.D., Chief Medical Service		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		LOCATION (City, town, or county) <u>Fort Myer, Virginia</u>		(State) <u>  </u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Mar 5/56</u>					
24. RECORD BY REGISTRAR <u>March 7, 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Lark</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
R. V. Singleton, Funeral Home, Glen Burnie, Maryland							

BUREAU V. 81

MAR 7 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02611  
41

2516

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Dundalk 22</u>		LENGTH OF STAY (in this place) <u>51 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>300 SOLLERS POINT ROAD</u>				STREET ADDRESS (If rural, give location) <u>300 SOLLERS POINT ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>ANN</u>		(First) <u>CATHERINE</u>		(Last) <u>NEAL</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>September 12, 1871</u>		9. AGE last birthday <u>84 yrs.</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles County, Maryland</u>	
13. FATHER'S NAME <u>David Greer</u>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. Sarah Neal Williams 300 Sollers Point Rd.</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) UREMIA

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Broncho - PNEUMONIA(c) HepatitisINTERVAL BETWEEN  
ONSET AND DEATH4 days7 days3 wks11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)  
SUICIDE  
HOMICIDEPLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at ☐ Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from Jan 3....., 1950., to March 18...., 1956., that I last saw the deceased  
alive on March 18...., 1956., and that death occurred at 3:20.....m., from the causes and on the date stated above.  
SIGNATURE \_\_\_\_\_ (Degree or title) ADDRESS \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

23. BURIAL, CREMATION  
REMOVAL (Specify)  
BurialDATE THEREOF  
3/27/56NAME OF CEMETERY OR CREMATORY  
Mt. Calvary

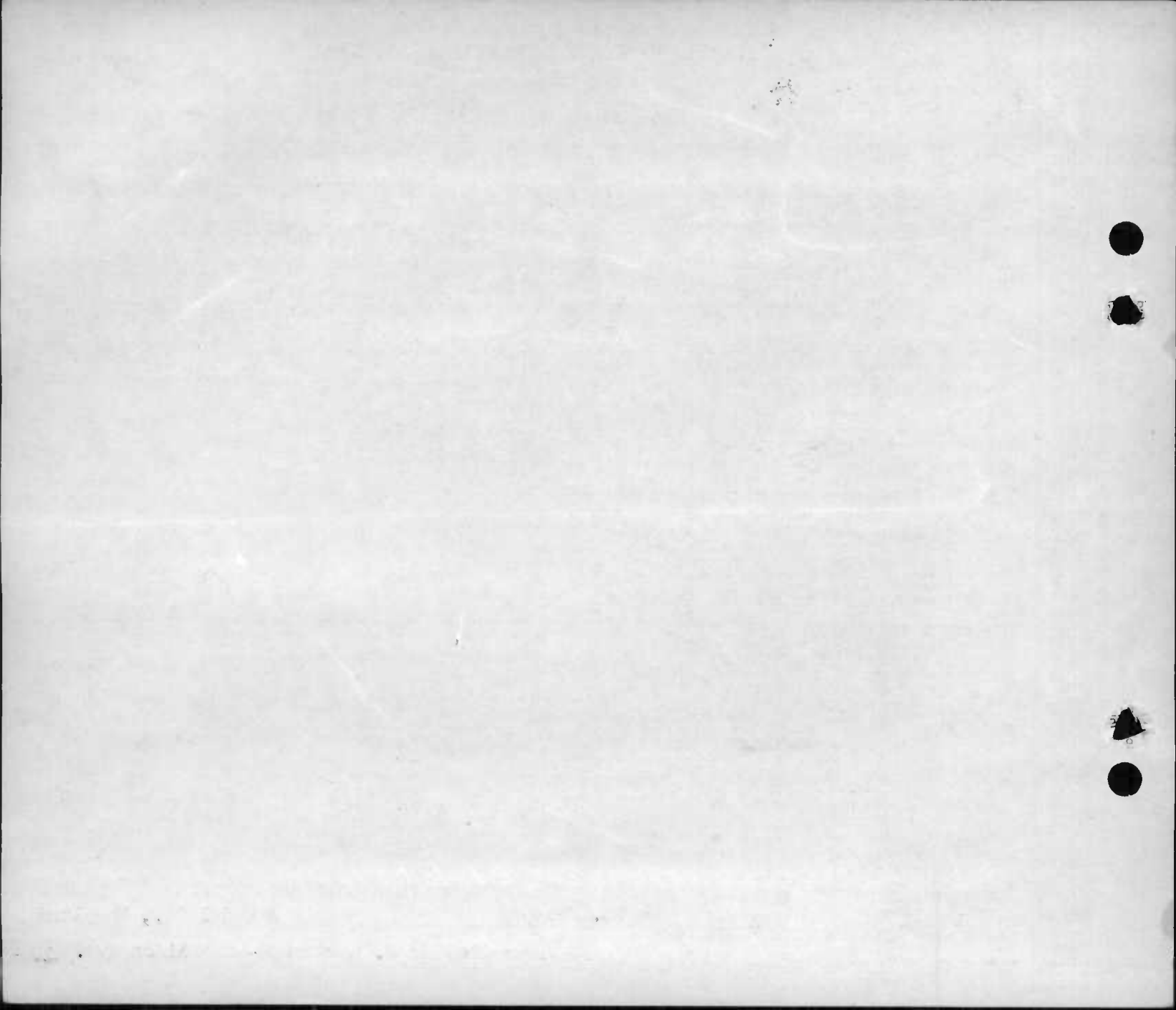
LOCATION (City, town, or county)

(State)  
MarylandDATE REC'D BY LOCAL  
REG. 3-20-56REGISTRAR'S SIGNATURE  
Edrick24. FUNERAL DIRECTOR  
Charles R. LawADDRESS  
802-04 Madison Ave.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2624

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.,</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>William H. Mason</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May, 3, 1878</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Scott Nason</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Henry Mason</b>		Address <b>Joppa, Harford Co., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>352x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stasis - paralysis</b> DUE TO (c) <b>Cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>7 days</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1956</b> , to <b>March 11, 1956</b> , that I last saw the deceased alive on <b>March 9, 1956</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William A. Tyson</b> M.D.				ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>3-11-56</b>			
PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 14, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Loreley, Balto., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McComas &amp; Son</b>				ADDRESS <b>Abingdon, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>3-14-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. A. Tyson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>14 Spring Grove Hospital</b>		d. STREET ADDRESS <b>3115 CLIFMONT AVE</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES F. NEUS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-1889</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ADAM (JOHN) NEUS, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE WOLFE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Hosp. Rec'd. &amp; Paul Neus - Nephew</b>		Address <b>City - 1526 Oakridge Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>with pulmonary congestion - terminal</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <b>pneumonitis, Rt. Lower lung</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-23-1956</b> , to <b>3-24-1956</b> , that I last saw the deceased alive on <b>3-24-1956</b> , and that death occurred at <b>1:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring Grove Hosp, Catonsville, Md.</b> DATE SIGNED <b>3-24-56</b>			
ACTUAL SIGNATURE <b>David E. Edwards</b>		PHYSICIAN'S NAME (Type) <b>DAVID E. EDWARDS MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore - Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart Mowen</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>V. E. Harry</b>		24c. DATE <b>APR 27 1956</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 CERTIFICATE OF DEATH

RECEIVED  
 MAR 27 1956  
 BUREAU V. S.

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		PLACE OF BIRTH _____	
OCCUPATION _____		EDUCATION _____		MARITAL STATUS _____	
PREVIOUS ILLNESS _____		MEDICAL HISTORY _____		SURVIVAL OF SURVIVORS _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____		SIGNATURE OF JUDGE _____	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.  
 AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT OF THE CITY OR COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

2626

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN 1b <b>28yrs. 1mth.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 SPRING GROVE STATE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>F.</b> Last <b>Osterman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-17-1892</b> <b>unknown</b>
9. AGE (In years last birthday) <b>62?</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chauffer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Adam Osterman</b> <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA BOHL</b> <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>NO</b> <b>unknown</b>	
17. INFORMANT <b>Records of Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>11</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 3, 1956</b> , to <b>March 15, 1956</b> , that I last saw the deceased alive on <b>March 15, 1956</b> , and that death occurred at <b>10:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. Glyne Williams</b> Clinical Director		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> <b>Catonsville 28, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>T. Glyne Williams, M. D.</b>		DATE SIGNED <b>3-16-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-17-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LODOW PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b> <b>md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glenn F. Setz</b>		ADDRESS <b>5209 York Rd</b>	
24a. REC'D BY REGISTRAR <b>March 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>F.E. Harvey</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







02614

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2627 CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. NAME OF DECEASED  
(Type or Print)

Mrs. Anna E. Payson

2. DATE  
OF  
DEATH

Mar 10, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore County*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

6129 Marglen Avenue

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4221 Berger Avenue #6

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 2, 1896

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Strunge

14. MOTHER'S MAIDEN NAME

Magdalene Beelat

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. William Payson, 4221 Berger Avenue

18. *170X*

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Cerebral Metastases*

DUE TO

*3 days*

## ANTECEDENT CAUSES

(B)

*Carcinoma right breast*

DUE TO

*4 years*DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER INPART I OR PART II  
21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR

22. I certify that (I) (this hospital) attended the deceased from *Jan. 1956* to *March 1956*, that (I) (we) last saw the deceased alive on *3-6* 19 *56*,  
and that death occurred at *11* a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☒MED. DIRECTOR ☐STAFF PHYS ☐

M.D.

*3105 Belair Rd**3-10-56*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

Mar. 14, 1956

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 13 1956

*Leonard J. Ruck*

Leonard J. Ruck, 5305 Harford Road #14

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

BUREAU V. S.

MAR 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03760  
2628 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. NAME OF DECEASED (Type or Print) <b>Dora Peterson</b>			2. DATE OF DEATH <b>March 11, 1956</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Co.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1249 Primrose Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Md.</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1249 Primrose Ave.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 27, 1889</b>		9. AGE (in years last birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Adam Schmitt</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Schmitel</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT ADDRESS <b>Elizabeth Rappold 1249 Primrose Ave.</b>		
18. <b>420.0</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. <b>260X</b>			DUE TO <b>Anteriorly but line</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetic mellitus</b>			DUE TO <b>Diabetic mellitus</b>		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August 27, 1953</b> , to <b>March 11, 1956</b> , that I last saw the deceased alive on <b>Feb 15, 1956</b> , and that death occurred at <b>6:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>James R. Schmitt, M.D.</b>		23B. ADDRESS <b>8019 Philadelphia Rd.</b>		23C. DATE SIGNED <b>3-12-56</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-14-56</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>B. Dabrowski 2818 E. Baltimore St.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>MAR 13 1956</b>		REGISTRAR'S SIGNATURE <b>Dr. J. Rappold</b>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially int. Physicians: please write the causes of death clearly and legibly.

y. The

This certificate is not valid unless it is signed by the Registrar of the State of New York, and the death is reported to the Registrar of the State of New York.

24. RURAL DIRECTOR ADDRESS		23. RURAL CREATION DATE OF CREATION REMOVAL (if any)		22. I hereby certify that I attended the funeral of and that death occurred at on the day of the year 19	
25. RURAL DIRECTOR ADDRESS		26. RURAL DIRECTOR ADDRESS		27. RURAL DIRECTOR ADDRESS	
28. RURAL DIRECTOR ADDRESS		29. RURAL DIRECTOR ADDRESS		30. RURAL DIRECTOR ADDRESS	
31. RURAL DIRECTOR ADDRESS		32. RURAL DIRECTOR ADDRESS		33. RURAL DIRECTOR ADDRESS	
34. RURAL DIRECTOR ADDRESS		35. RURAL DIRECTOR ADDRESS		36. RURAL DIRECTOR ADDRESS	
37. RURAL DIRECTOR ADDRESS		38. RURAL DIRECTOR ADDRESS		39. RURAL DIRECTOR ADDRESS	
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BUREAU V. S.

APR 25 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2629

## CERTIFICATE OF DEATH

Reg. Dist. No. 02615

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>83 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>639 Main</b>			d. STREET ADDRESS <b>639 Main</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Hannah</b> Middle <b>May</b> Last <b>Pfeffer</b>			4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 26, 1872</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Reisterstown, Md.</b>	
13. FATHER'S NAME <b>William A. Russell</b>			14. MOTHER'S MAIDEN NAME <b>Abbie Ann Martin</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>K. Russell Pfeffer, Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Rheumatic Arteriosclerotic C-V Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>11 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
		20f. (City or town) <b>none</b>		(County) (State)	
21. I certify that I attended the deceased from <b>3-8-45</b> , 19 <b>45</b> , to <b>3-15-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-22-56</b> , 19 <b>56</b> , and that death occurred at <b>11:30 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd., Reisterstown, Md.</b> DATE SIGNED <b>3-19-56</b>					
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. <b>D. D. Caples, M. D.</b>			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Luthern</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>3-19-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

MAR 21 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2630

## CERTIFICATE OF DEATH

02616  
33

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Rosewood State Dr. School</u>				d. STREET ADDRESS <u>1010 Boyd</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PIERSON</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-06</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patient at Rosewood</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Howard Pierson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Farrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address <u>Rosewood Owings Mills, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardia failure: Cor Pulmonale</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>002X</u> (b) <u>Bright's Disease, sclerotic, hypertensive</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1</u> , 19 <u>56</u> to <u>Mar 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>56</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wesley B. Johns</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/24/56</u>			
PHYSICIAN'S NAME (Type) <u>M.D. Rosewood State Dr. Sch</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Elmer, Sons Rustertown Md</u>				24a. REC'D BY REGISTRAR DATE <u>3-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wesley B. Johns</u>	

CERTIFICATE OF DEATH

3830

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MANNER OF DEATH                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
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<p>97. SIGNATURE OF JURY                  [Faint text]</p>		<p>98. SIGNATURE OF JURY                  [Faint text]</p>	
<p>99. SIGNATURE OF JURY                  [Faint text]</p>		<p>100. SIGNATURE OF JURY                  [Faint text]</p>	

BUREAU V. S.

APR 2 1958

RECEIVED

2631

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## I. PLACE OF DEATH:

COUNTY Baltimore · 19 · MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) SPARROWS Pt. LENGTH OF STAY (in this place) 18 yrs  
 TOWN SPARROWS Pt.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 2514 Sycamore Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY MD  
 CITY (If outside corporate limits, write RURAL and give nearest town) MD  
 TOWN MD  
 STREET ADDRESS # 1 (If rural, give location) 1

## 3. NAME OF DECEASED:

(First) JOHN (Middle) POPE (Last) POPE

4. DATE OF DEATH: Mar 4 19 56

## 5. SEX:

Male

## 6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

## 8. DATE OF BIRTH:

Dec 24, 1905

## 9. AGE last birthday:

50 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Hauling

11. BIRTHPLACE (State or foreign country): Suffolk, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Wesley Pope

## 14. MOTHER'S M maiden NAME:

Helia Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no.

## 16. SOCIAL SECURITY No.:

217-34-9038

## 17. INFORMANT &amp; ADDRESS:

James Pope 2818 Lodge Farm Rd Balto 19.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2

Immediate cause

(a) DUE TO

Acute myocardial Failure -

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Chronic myocarditis.

2 yrs.

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Chronic bronchial asthma.

14 yrs.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from..... 19 42 to..... MAR 4, 19 56, that I last saw the deceased

live on..... MAR 1, 19 56, and that death occurred at..... 12 45 P....., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James N. Tollin, M.D. 6908 N. P+ Rd. Balto 19. Md. Mar. 4, 1956

23. BURIAL, CREMATION OR REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

3-7-1956

Mt Calvary Cemo C. A. Co

MD

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

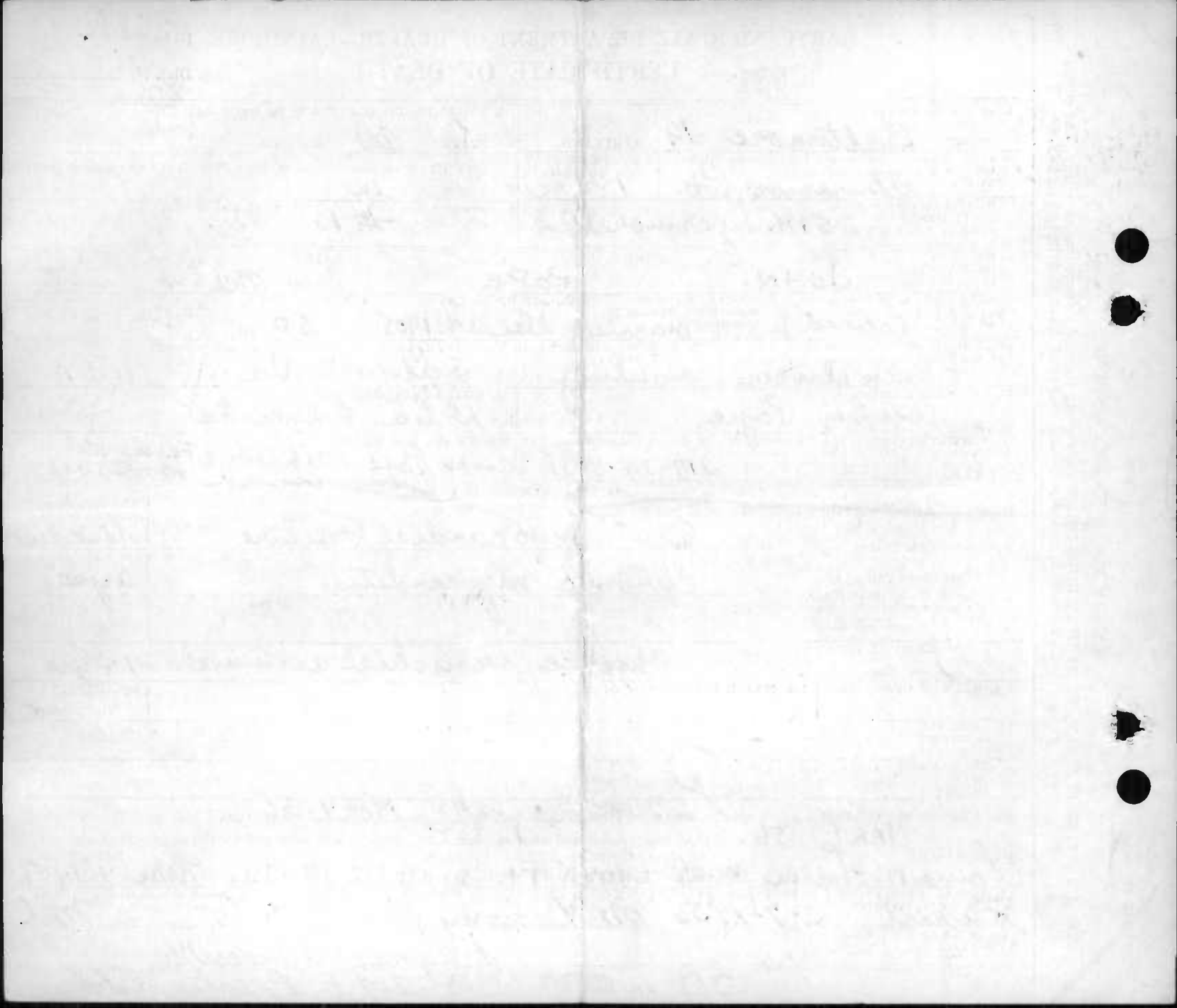
ADDRESS

3/7/56

Rayner Sanders

217 E Preston St

MARGIN RESERVED FOR BINDING



2632

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2005 Thayer Terrace</b>		d. STREET ADDRESS <b>2005 Thayer Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>Adele</b> Middle <b>G.</b> Last <b>Potter</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1873</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mortimer Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Sally B. Crapster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. P.H. Boyer</b>		Address <b>2005 Thayer Terrace (7)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>acute dilatation of heart</b> <b>422.1</b> DUE TO <b>cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>about 20 min.</b> <b>9</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> _____	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feb.</b>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>March 28</b> , 19 <b>56</b> , to <b>March 9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 9</b> , 19 <b>56</b> , and that death occurred at <b>7:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter S. Niblett</b>		DATE SIGNED <b>March 10/56</b>	
PHYSICIAN'S NAME (Type) <b>Walter S. Niblett</b>		ADDRESS <b>2220 Harrison Blvd</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-12-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		24. REC'D BY REGISTRAR <b>Dr. Wm. C. Martin</b>	
ADDRESS <b>3207 W. North Ave</b>		DATE <b>3/15/56</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9, Film G196 4-23-56 et

02619

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>50 Veterans Administration Hospital</u>		d. STREET ADDRESS <u>1704 Ruxton Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD (NMI) PRATT</u>		4. DATE OF DEATH Month Day Year <u>March 28 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1890</u>
9. AGE (In years last birthday) <u>65 33/4</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	
11. BIRTHPLACE (State or foreign country) <u>West River, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alec Pratt</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Clinical Records, Vet. Adm. Hosp. Ft. Howard, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 16, 1955</u> , to <u>March 28, 1956</u> , that the deceased <u>lived on</u> , <u>1206 E. 12th St.</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH Ft. Howard, Md</u> <u>3/29/56</u> ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. <u>VAH, FORT HOWARD, MD</u> <u>3/29/56</u> PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Low</u> <u>per W.M.</u> <u>Charles R. Low 802 Madison Ave. Balto. 7, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 3/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Harrison L. Parker</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10  
 CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]		7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]	
9. DATE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. MEDICAL HISTORY [Illegible]		14. PRESENT ILLNESS [Illegible]		15. TREATMENT [Illegible]		16. POST-MORTEM [Illegible]	
17. SIGNATURE OF PHYSICIAN [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]		19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF DECEASED [Illegible]	

**RECEIVED**  
 APR 3 1956  
 BUREAU V. S.

2634

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Randallstown</b>				TOWN <b>Randallstown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<b>9001 Liberty Road</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>Mary Frances Rainey</b>				OF DEATH: <b>3-10-56</b> 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>Aug 10, 1868</b>	<b>87</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>At Home</b>						<b>Ireland</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Unknown</b>				<b>Lena McSweeney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>No</b>						<b>John Patrick Rainey 9001 Liberty Road</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebral Vascular Accident -</b>							
ANTECEDENT CAUSE (S) DUE TO <b>Hypertensive C.V. disease - severe</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Hypertrophic cardiomyopathy - gen. severe</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 1, 1954</b> , to <b>March 10, 1956</b> , that I last saw the deceased <b>alive on Mar. 19, 1956</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Thomas E. Wheeler</b>				ADDRESS <b>3001 Cypress Rd - Balt 7</b>		DATE SIGNED <b>3/11/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>March 13, 56</b>		<b>New Cathedral</b>		<b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>3-12-56</b>		<b>J. J. Hedgcock</b>		<b>Ellsworth Armistead</b>		<b>4600 Liberty Heights Ave.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]

Re New York letter to Bureau dated 10/10/68.  
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.  
The LHM contains information received from [Illegible] regarding [Illegible] activities in New York City.  
This information was obtained from [Illegible] on 10/10/68.

The LHM also contains information regarding [Illegible] activities in New York City.  
This information was obtained from [Illegible] on 10/10/68.  
The LHM is being furnished to the Bureau for information and for the Bureau's use in its ongoing investigation of [Illegible].

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2523

## CERTIFICATE OF DEATH

02621  
47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. LENGTH OF STAY IN 1b <b>17 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>612 Gun Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Louisa</b> Last <b>Read</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> , Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 6, 1863</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward P. Shannon</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Hutchinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Viola Sonnenberg</b>		Address <b>612 Gun Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Generalized</b> (c) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Undet</b> <b>Undet.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 17</b> , 19 <b>54</b> , to <b>March 26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>56</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1264 Francis Ave, Baltimore Md</b> DATE SIGNED <b>3-26-56</b>			
ACTUAL SIGNATURE <b>A. Bradley Daugharthy</b> M.D.		PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-28-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		24. REG'D BY REGISTRAR <b>Dr. Leo M. Kipper</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE \_\_\_\_\_

10-10-68

7/11/98

1992

BUREAU V. S.

APR 3 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

02622

2635

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <b>Baltimore,</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore,</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Presbyterian Home</b>		STREET ADDRESS (If rural, give location) <b>802 St. Paul St.</b>	
3. NAME OF DECEASED (Type or Print) <b>Helen Mae</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>1,</b> (Year) <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Nov. 11, 1862</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>93</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William L. Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Ann Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mrs. Twilah Elliott Presbyterian Home</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 X Immediate cause

(a) *Pulmonary edema, hypostatic (terminal)*

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Cardio-renal-vascular disease*

Unknown

(c) *Senile changes with arteriosclerosis*

Unknown

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>HOMICIDE</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *June*, 195*1*, to *March 1st*, 195*6*, that I last saw the deceased alive on *Feb 29*, 195*6*, and that death occurred at *6:30 A.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

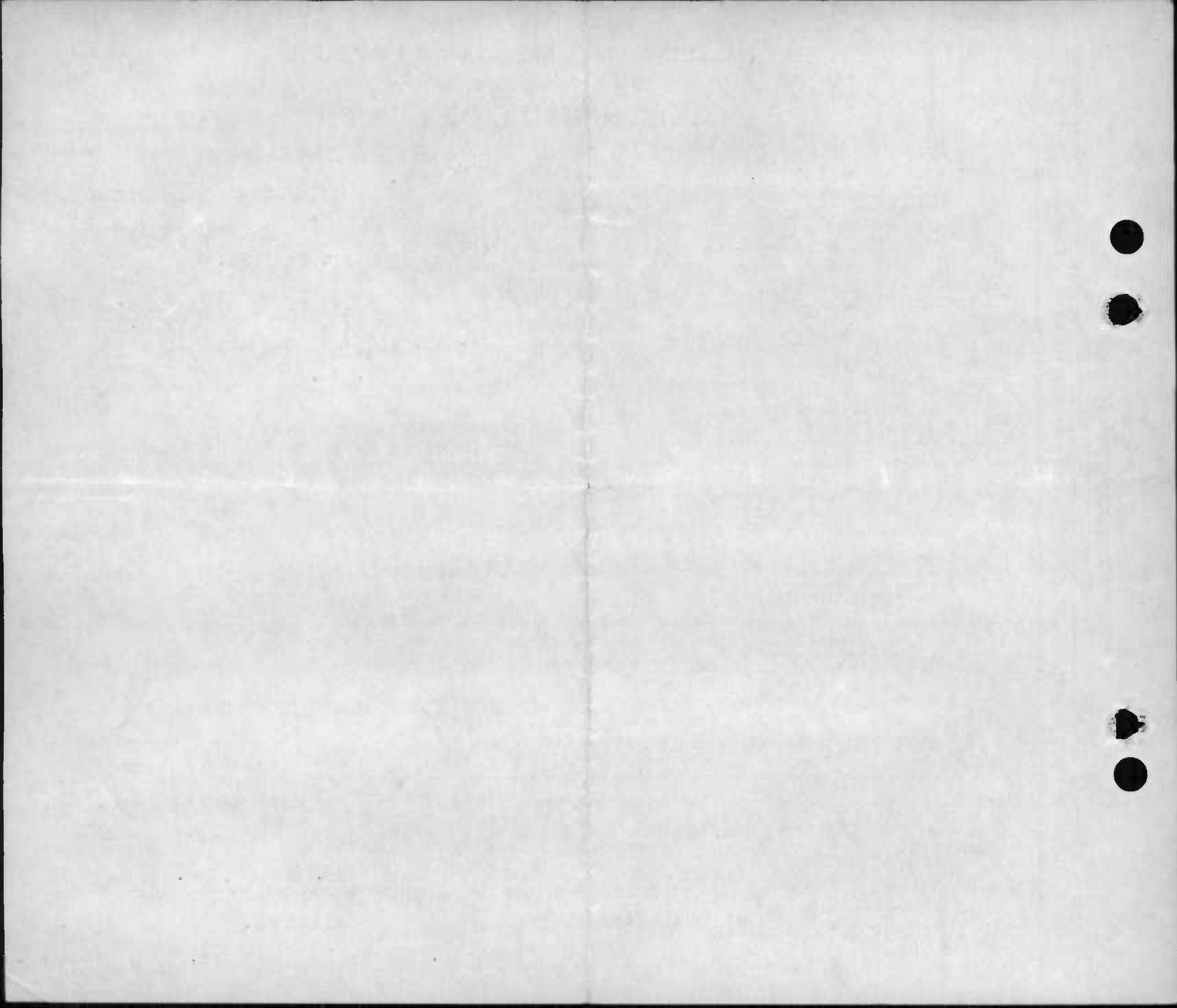
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>March 3, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	LOCATION (City, town, or county) <b>Baltimore,</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG. <i>March 3 1956</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>		24. FUNERAL DIRECTOR ADDRESS <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Pl.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2636

## CERTIFICATE OF DEATH

03772

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>17 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>50 Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>243 State Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWARD RIGGIN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1893</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter &amp; Sander</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Seth Riffin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Sterling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>218-14-2535</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA INVOLVING LIVER AND LYMPH NODES</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>VA</b> attended the deceased from <b>February 23, 1956</b> , to <b>March 11, 1956</b> and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3/12/56</b> ACTUAL SIGNATURE <b>Donald D. Mark</b> PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>American Legion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw Funeral Home, Crisfield, Maryland</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>3/15/56</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Dawson L. Parkes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased [Faint text, possibly "John Doe"]		Date of Death [Faint text, possibly "1955-11-15"]	
Sex [Faint text, possibly "Male"]		Age [Faint text, possibly "45"]	
Race [Faint text, possibly "White"]		Marital Status [Faint text, possibly "Married"]	
Usual Residence [Faint text, possibly "123 Main St, Baltimore, MD"]		Place of Death [Faint text, possibly "Home"]	
Cause of Death (Immediate) [Faint text, possibly "Heart Disease"]		Cause of Death (Underlying) [Faint text, possibly "Coronary Artery Disease"]	
Date of Birth [Faint text, possibly "1910-01-01"]		Date of Death [Faint text, possibly "1955-11-15"]	
Signature of Physician [Faint signature]		Signature of Registrar [Faint signature]	
Date of Signature [Faint text, possibly "1955-11-15"]		Date of Signature [Faint text, possibly "1955-11-15"]	

BUREAU V. 2

MAR 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02623

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 month 4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">3701-4 ✓</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 Spring Grove State Hospital</b>				d. STREET ADDRESS <b>Allendale</b> <b>2501 Allendale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>A.</b> Last <b>Riley</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7,</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-17-1882</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown Alexander Abrams</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Ida McCoovray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records Spring Grove State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Therapeutic misadventure due to electric shock therapy</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Electric shock therapy</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10</b> <b>3-7-</b> <b>19 56</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Catonsville Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George S. M. Kieffer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-7-56</b>	
EXAMINER'S NAME (Type) <b>George S. M. Kieffer, M. D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balto</b>				ADDRESS <b>17 MAR 8 1956</b>		24b. REGISTRAR'S SIGNATURE <b>P. E. Harry</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		1910		New York		New York		Heart Disease		Natural	
Occupation		Marital Status		Education		Religion		Race		Color		Date of Death		Time of Death	
Teacher		Married		High School		Catholic		White		White		1956		10:00 AM	
Place of Death		Hospital		Physician		Nurse		Attending Physician		Medical Examiner		Signature		Signature	
St. Mary's Hospital		St. Mary's Hospital		Dr. John Smith		Mrs. Jane Doe		Dr. John Smith		Dr. John Smith		[Signature]		[Signature]	
City		County		State		Country		Latitude		Longitude		Elevation		Temperature	
Baltimore		Baltimore		Maryland		USA		39° 15' N		76° 30' W		100 ft		70°F	
Weather		Wind		Humidity		Barometer		Moon		Stars		Clouds		Sun	
Clear		Light		60%		30.0		None		None		None		None	
Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks		Remarks	
No autopsy performed		No autopsy performed		No autopsy performed		No autopsy performed		No autopsy performed		No autopsy performed		No autopsy performed		No autopsy performed	
Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAR 9 1956

RECEIVED



2638

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		OR TOWN <u>Colgate</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>508 Old North Point Road</u>				STREET ADDRESS (If rural give location) <u>508 Old North Point Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elizabeth S Rippel</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>March 18 / 56</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>April 20, 1886</u>	
9. AGE last birthday: <u>69</u> yrs.		10. MONTHS <u>18</u> DAYS <u>19</u> HOURS <u>19</u> MIN.		9. AGE last birthday: <u>69</u> yrs.		10. MONTHS <u>18</u> DAYS <u>19</u> HOURS <u>19</u> MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>George Bauer</u>			
14. MOTHER'S MAIDEN NAME: <u>Lena Frederick</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>William Rippel 508 Old North Point Road</u>				17. INFORMANT & ADDRESS: <u>William Rippel 508 Old North Point Road</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>446x</u> Immediate cause (a) <u>Uremia</u>		<u>6 weeks</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Nephrosclerosis</u>		<u>2 years</u>
(c) <u>Cervical Spondylosis</u>		<u>5 years</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct 8, 1952, to March 18, 1956, that I last saw the deceased alive on March 15, 1956, and that death occurred at 10:09 AM, from the causes and on the date stated above.

SIGNATURE <u>Thomas A. J. [Signature]</u>		ADDRESS <u>1010 North Point Rd</u>		DATE SIGNED <u>3/19/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>
LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>		DATE REC'D BY LOCAL REGISTRAR <u>3-21-56</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

25051

2639

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperoo (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperoo (Rural)</u> x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>- E -</u> Middle <u>RUBY</u> Last		4. DATE OF DEATH <u>May</u> Month <u>14</u> Day <u>1956</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 - 1896</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crooner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Team</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harward Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Rora Glas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Geo E Ruby</u> Address <u>Upperoo Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma Pancreas</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>4 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> 19 <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 14</u> , 19 <u>56</u> , to <u>March 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>3/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Balto co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>3-17-56</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Mary S. Eline.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02626

Reg. Dist. No. 33

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY _____</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <span style="float: right;">3Y01-4 ✓</span> d. STREET ADDRESS <u>1411 Division Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bessie Forman Saul (Sauls)</u> First Middle Last <b>4. DATE OF DEATH</b> <u>March 22</u> <span style="float: right;">1956</span> Month Day Year				<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 1 1907</u> <b>9. AGE</b> (In years last birthday) <u>48</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cook</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Private Family Wilson</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Francis Griffith</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>215-30-0241</u> <b>17. INFORMANT</b> <u>Jessie Artis</u> <span style="float: right;">Address <u>2207 Liberty Hgts. Ave.</u></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Anaphylactic Reaction</u> <b>DUE TO</b> <b>(b)</b> <u>Bronchitis</u> <b>(c)</b> <u>Tonsillitis</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1/2 hr.</u> <u>24 hrs.</u> <u>24 hrs.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>none</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>none</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>			
<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>D. D. Caples</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <span style="float: right;">3-23-56</span> <b>DATE SIGNED</b>		<b>EXAMINER'S NAME (Type)</b> <u>Dr. D. D. Caples</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-25-66</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Auburn</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Mt. Winans</u> <b>(State)</b> <u>Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Mary Elie</u> <b>24b. REGISTRAR'S SIGNATURE</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles R. Law</u> <b>ADDRESS</b> <u>802-04 Madison Ave.</u>				<b>DATE</b> <u>MAR 27 1956</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

19  
HARTFORD STATE DEPARTMENT OF HEALTH - BATTLEMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. S.

MAR 27 1956

RECEIVED



02627

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2641

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 Catonsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>52 Catonsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>90 Caton Ridge Nursing Home</b>				STREET ADDRESS (If rural give location) <b>Harlem Lane</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Leon Schmidt Sr.</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>March 7, 1956 19</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Separated</b>	8. DATE OF BIRTH: <b>Aug 12, 1886</b>	9. AGE last birthday: <b>69</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farm Hand</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Unknown</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-8707A</b>		17. INFORMANT & ADDRESS: <b>Mrs. Mary Torgerson 1817 E. Pratt Street</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE		(A) <b>Cerebro vascular accident</b>				<b>24 hrs</b>	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <b>Arterio sclerosis Cerebral</b>				<b>unknown</b>	
		DUE TO					
		(C) <b>Diabetes mellitus</b>				<b>unknown</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4/20, 1955</b> , to <b>3/7, 1956</b> , that I last saw the deceased alive on <b>3/6, 1956</b> , and that death occurred at <b>5<sup>th</sup> AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Curtis Duggs Jr.</b>		M.D. <b>46-5</b>		ADDRESS <b>Edmonds Ave</b>		DATE SIGNED <b>3/9/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3-9-56</b>		NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>9 1956</b>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <b>Ellsworth Arnacost</b>		ADDRESS <b>4600 Liberty Heights</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1956

RECEIVED

2642

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Middle River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River 20ome. 54</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>00 AUGUSTA SCHUBERT</i>		d. STREET ADDRESS <i># 250 Chesapeake Ave</i>	
3. NAME OF DECEASED (Type or print) <i>1 AUGUSTA Louise Schubert</i>		4. DATE OF DEATH Month <i>March</i> Day <i>12</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-8-1881</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wm. Tornollin</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Molschleger</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>same.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 arteriosclerotic heart disease</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 Basal cell Carcinoma forehead 2 Severe osteoporosis spine</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 26</i> , 19 <i>54</i> , to <i>March 12</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>March 9</i> , 19 <i>56</i> , and that death occurred at <i>9P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. L. Kolodny, MD</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>1825 Eastern Blvd Baltimore 21, MD 3/13/56</i>	
PHYSICIAN'S NAME (Type) <i>A. L. Kolodny, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-13-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Khwant Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Bugdzinski 1407 Eastern Ave</i>		24a. REC'D BY REGISTRAR DATE <i>3/14/56</i>	24b. REGISTRAR'S SIGNATURE <i>Earle Hurley</i>

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

JUN 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

02629

2643

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>902 Edmondson Ave</b>			STREET ADDRESS (If rural, give location) <b>902 Edmondson Ave.</b>		
3. NAME OF DECEASED (Type or Print) <b>CHARLES</b> (First) <b>SCOTT</b> (Middle) (Last)			4. DATE OF DEATH <b>3</b> (Month) <b>6</b> (Day) <b>1956</b> (Year)		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 27, 1937</b>		9. AGE last birthday <b>18</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>John Scott</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMYE FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY No.		
17. INFORMANT AND ADDRESS <b>M's Veretta Scott 902 Edmondson Av</b>			14. MOTHER'S MAIDEN NAME <b>Mary ?</b>		

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
289.0 Immediate cause (a) <b>Internal hemorrhage - possible splenic laceration</b>				<b>18 hrs</b>	
Antecedent cause(s) (b) <b>Lacerated spleen</b>				<b>3 years</b>	
(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct**, 19**55**, to **March**, 19**56**, that I last saw the deceased alive on **6 March**, 19**56**, and that death occurred at **6:00 A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

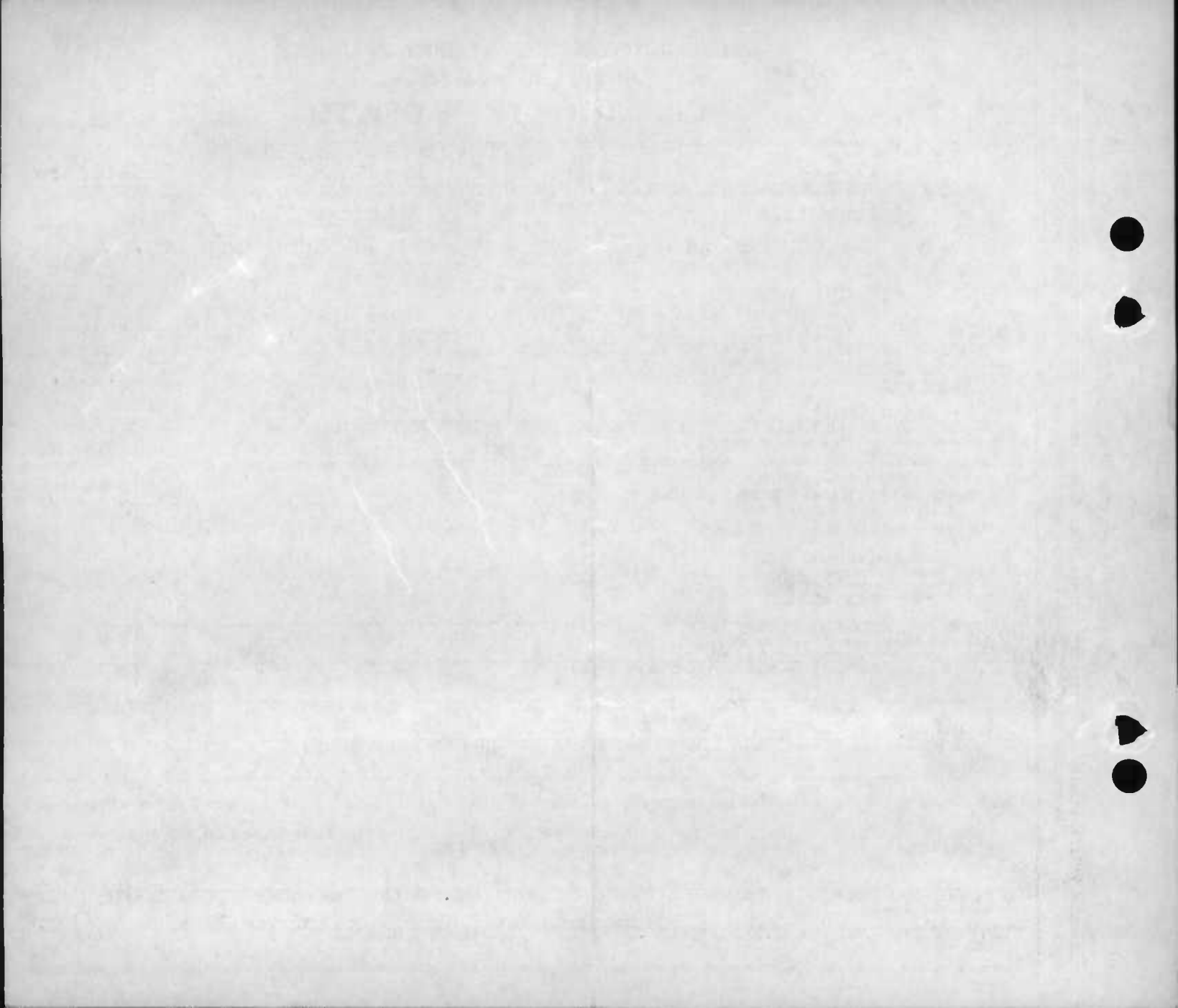
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>3-9-56</b>	NAME OF CEMETERY OR CREMATORY <b>Western Star Cem</b>	LOCATION (City, town, or county) <b>Catonsville</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <b>Matthew C. Hendry (W) Bickley</b>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





2644

## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

02630

38

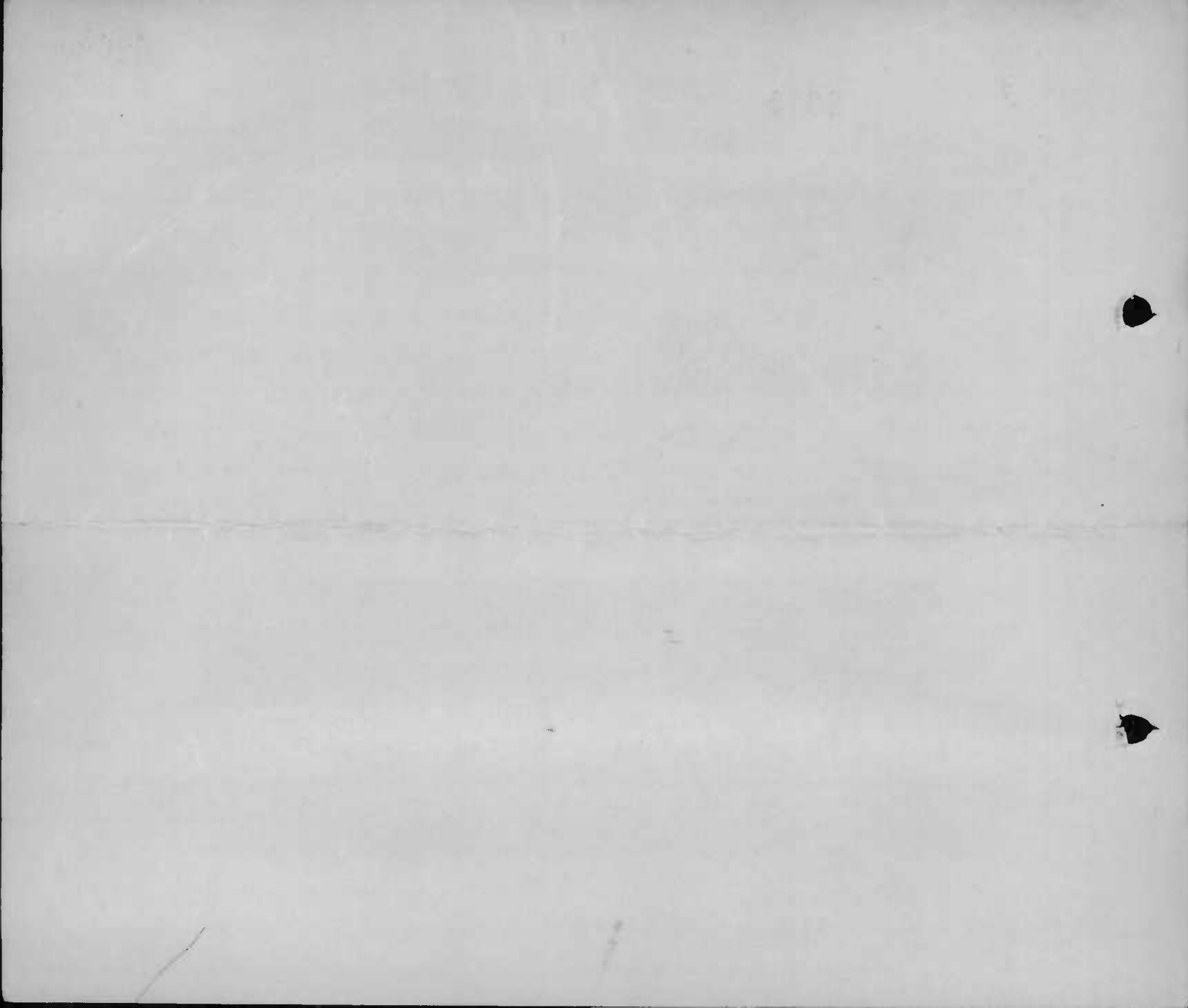
1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 May Ave</u>		STREET ADDRESS (If rural, give location) <u>9 MAY AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>JENNIE</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAY 6, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	9. AGE last birthday <u>52</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTO. CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thos. SCOVENS</u>		14. MOTHER'S MAIDEN NAME <u>CAIRO FORSTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. INFORMANT AND ADDRESS <u>W. K. K... SKESTER SCOVENS-2400 Guilford Ave</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Cough &amp; Cold for 1 Month.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General Upper Respiratory Infection 1 Month</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Charles F. Donnell</u>		ADDRESS <u>7501 York Rd Towson #4 and 3/56</u>	
DATE SIGNED <u>March 3rd 1956</u>		DATE SIGNED <u>March 3rd 1956</u>	
23. REMOVAL OF REMAINS (Specify) <u>BURIAL</u>	DATE THEREOF <u>3/5/56</u>	NAME OF CEMETERY OR CREMATORY <u>PLEASANT REST</u>	LOCATION (City, town, or county) (State) <u>TOWSON, MD</u>
DATE REC'D BY LOCAL REG. <u>March 3rd 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Wm. E. Chatman, Jr.</u>		ADDRESS <u>1201 Mt. Chubb St BALTO. MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02631

2645 **CERTIFICATE OF DEATH**

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		<u>02X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #1, Box 317</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM R. SEDGWICK</u>				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 2, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Horace Sedgwick</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Offeri</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>215-07-7860</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
155X IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE BILIARY TRACT</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that</b> <u>VA</u> <del>X</del> attended the deceased from <u>March 2, 1956</u> , to <u>March 7, 1956</u> , <del>when he was the deceased</del> <del>and that death occurred at 1:30AM, from the causes and on the date stated above.</del> SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>Baltimore, Maryland</u> DATE SIGNED <u>3/7/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 12 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah Brown Funeral Home</u>		ADDRESS <u>108 Montgomery St. Baltimore, Maryland</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1950

DATE OF DEATH

1. NAME OF DECEASED (Print Name)

MARYLAND

COUNTY

SEX OF DECEASED

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

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INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

BUREAU V. S.

MAR 13 1950

RECEIVED

2007/10/10

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY REGISTERED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

2646

## CERTIFICATE OF DEATH

02632

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>501 RIVERSIDE DRIVE</b>				d. STREET ADDRESS <b>501 RIVERSIDE DRIVE</b>			
3. NAME OF DECEASED (Type or print) <b>CAROLINE</b> First <b>M. SCHOOK</b> Middle Last				4. DATE OF DEATH <b>MARCH</b> Month <b>25</b> 1956 Day Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 13, 1887</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>JOHN KOENIG</b>			14. MOTHER'S MAIDEN NAME <b>LILLIAN WOLFE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>179-16-682</b>		17. INFORMANT <b>LEROEY E. GERDING ATT. 220 S. HIGHLAND AVE.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> (b) <b>arterio-sclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/10/47</b> 19____, to <b>3/25/56</b> 19____, that I last saw the deceased alive on <b>11/30/55</b> 19____, and that death occurred at <b>760 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>423 Eastern Ave Bronx 21st 36/56</b> DATE SIGNED ACTUAL SIGNATURE <b>Joseph Miceli</b> M.D. PHYSICIAN'S NAME (Type) <b>JOSEPH MICELI M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>3/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>SUNBURY, PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Brudzinski</b>				ADDRESS <b>1407 Eastern Ave</b>		24a. REC'D BY REGISTRAR DATE <b>3/26/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 28 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2647  
CERTIFICATE OF DEATH

02633

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>42 Westminster Road</b>				d. STREET ADDRESS <b>42 Westminster Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Kathence</b> Last <b>Shamberger</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>56</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1885</b>		9. AGE (In years last birthday) <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs, John Wynn Morgonton, North Carolina</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 13</b> , 19 <b>54</b> , to <b>March 9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 5</b> , 19 <b>56</b> , and that death occurred at <b>Reisterstown, Md.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence E. McWilliams</b> M.D.				ADDRESS (Street, city or town, state) <b>Reisterstown, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence E. McWilliams</b>				DATE SIGNED <b>March 10, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 12, 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Son's Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

2648 Item 12, Film G194 4-3-56 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

02634

Reg. Dist. No.

Items 8, 9, Film G195 4-16-56 et

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>AARON</b> Middle <b>SHULMAN</b> Last <b>SHULMAN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/9/1911-1-03</b>
9. AGE (In years last birthday) <b>53 52/100</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fur</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Shulman</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Schweisberg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>Yes</b> (If yes, give year or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clin. Rec., Vet Adm Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 Minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 21, 1956</b> to <b>March 25, 1956</b> and that death occurred at <b>10:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>3/25/56</b>			
ACTUAL SIGNATURE <b>Rafael Longo</b>		M.D. <b>VAH, Fort Howard, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>RAFAEL LONGO, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Hebrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jacob Lewis Inc</b>		24a. REC'D BY REGISTRAR - <b>MAR 27 1956</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Larkins</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

MAR 27 1956

RECEIVED

2649

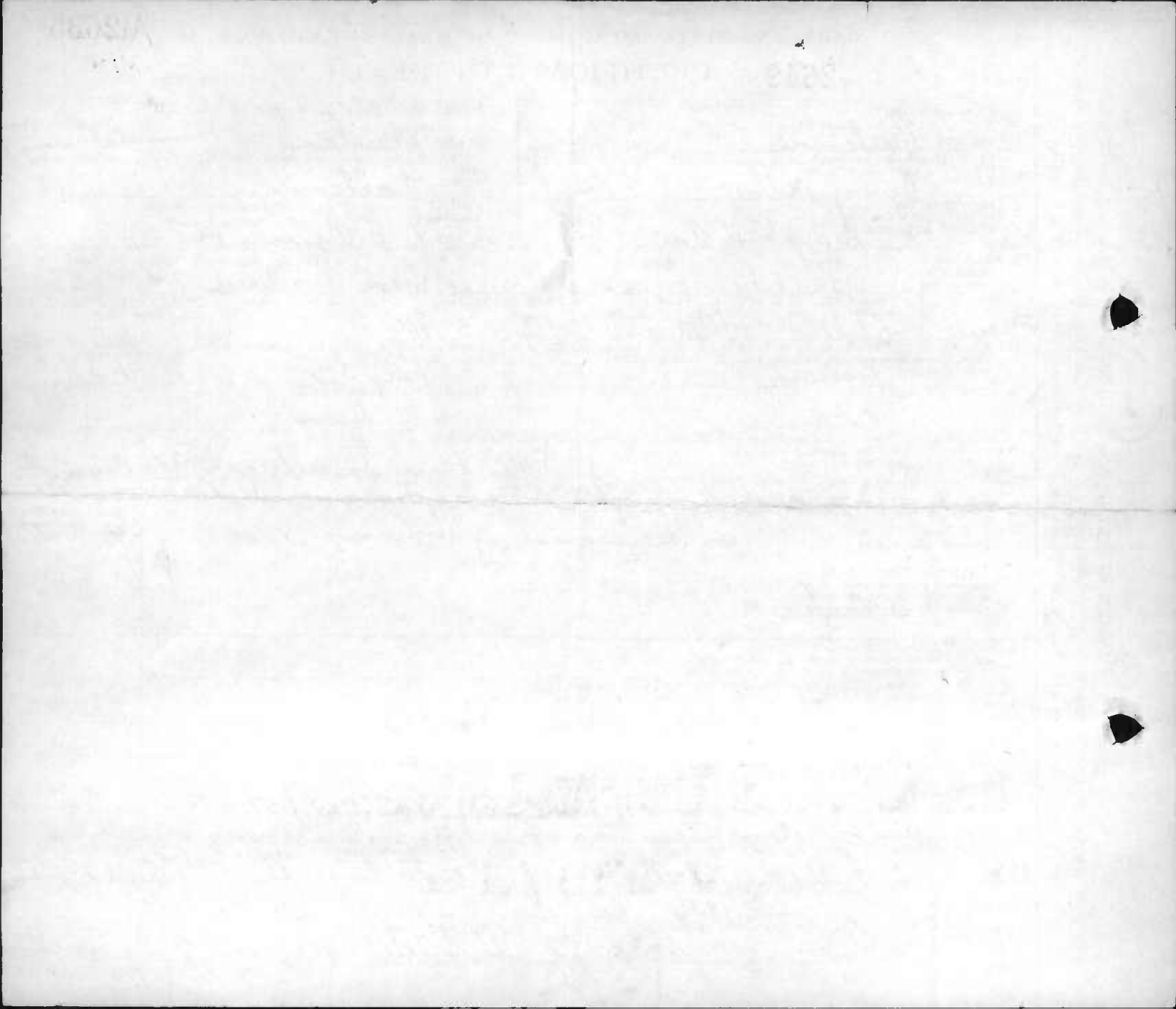
## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Owens Mills</u>		RURAL LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore</u>		3V01.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Greenbrook Ave</u>				STREET ADDRESS (If rural give location) <u>2508 E. Madison St.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>DOROTHY ELIZABETH SISELBERGER</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>March 24 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>October 13 1904</u>	
9. AGE last birthday: <u>51</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mr. Revere</u>				14. MOTHER'S M maiden name: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>Mr. Harry Sisselberger</u>			
17. INFORMANT & ADDRESS: <u>2508 E. Madison St. Baltimore, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X Immediate cause (a) <u>Carcinoma, pulmonary</u>							
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 23, 1956</u> , to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Clarence E. McWilliams M.D.</u>				DATE SIGNED <u>March 24/1956</u>			
(Degree or title)				ADDRESS <u>Reisterstown Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 26/1956</u>		<u>Baltimore Cemetery</u>		<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-56</u>		<u>[Signature]</u>		<u>John C. Miller Inc.</u>		<u>2431 E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02636

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7mos.10days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>			d. STREET ADDRESS <b>2827 Bauernwood Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Herbert</b> Last <b>Slaughter</b>			4. DATE OF DEATH Month <b>March</b> Day <b>27</b> , Year <b>19 56</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-1877</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Mr. James Slaughter</b>			14. MOTHER'S MAIDEN NAME <b>Sullivan</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>218-12-2580</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>90 4.7</b> (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Undetermined</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Unknown</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
				20f. (City or town) (County) (State) <b>Catonsville Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>George S. M. Kieffer</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>George S. M. Kieffer</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road</b>			24a. REC'D BY REGISTRAR <b>April 2, 1956</b>		
			24b. REGISTRAR'S SIGNATURE <i>T. E. Harry</i>		



2651 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3414 Juneway</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES W. SLITZER</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 5, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-28-95</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Policeman</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Lewis Slitzer</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Bamburger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW 1</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>LAENNEC'S CIRRHOSIS</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Feb. 29, 1956</u> to <u>Mar. 5, 1956</u> and that death occurred at <u>5:55 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3-6-56</u>			
23. REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>March 7, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>M.F. SADOWSKI &amp; SONS</u> <u>1808 Eastern Ave., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL

1. NAME (Last, first, middle initial)

2. DATE OF BIRTH (Month, day, year)

3. SEX (Male, Female)

4. RACE (White, Negro, American Indian, Alaska Native, Hawaiian, Other)

5. OCCUPATION (Type of work)

6. EDUCATION (Grade completed)

7. MARITAL STATUS (Single, Married, Divorced, Widowed)

8. RELIGION (If any)

9. ADDRESS (Street, city, state, zip)

10. PHONE NUMBER (Area code, number)

11. EMPLOYER (Name of company or organization)

12. SOCIAL SECURITY NUMBER (If any)

13. DATE OF INTERVIEW (Month, day, year)

14. INTERVIEWER (Name of person conducting interview)

15. SOURCE OF REFERENCE (Name of person who referred you)

16. DATE OF REFERENCE (Month, day, year)

17. REASON FOR REFERENCE (Why were you referred?)

18. DATE OF REFERENCE (Month, day, year)

19. ADDRESS (Street, city, state, zip)

20. PHONE NUMBER (Area code, number)

21. EMPLOYER (Name of company or organization)

22. SOCIAL SECURITY NUMBER (If any)

23. DATE OF INTERVIEW (Month, day, year)

24. INTERVIEWER (Name of person conducting interview)

25. SOURCE OF REFERENCE (Name of person who referred you)

26. DATE OF REFERENCE (Month, day, year)

27. REASON FOR REFERENCE (Why were you referred?)

28. DATE OF REFERENCE (Month, day, year)

29. ADDRESS (Street, city, state, zip)

30. PHONE NUMBER (Area code, number)

31. EMPLOYER (Name of company or organization)

32. SOCIAL SECURITY NUMBER (If any)

33. DATE OF INTERVIEW (Month, day, year)

34. INTERVIEWER (Name of person conducting interview)

35. SOURCE OF REFERENCE (Name of person who referred you)

36. DATE OF REFERENCE (Month, day, year)

37. REASON FOR REFERENCE (Why were you referred?)

38. DATE OF REFERENCE (Month, day, year)

39. ADDRESS (Street, city, state, zip)

40. PHONE NUMBER (Area code, number)

41. EMPLOYER (Name of company or organization)

42. SOCIAL SECURITY NUMBER (If any)

43. DATE OF INTERVIEW (Month, day, year)

44. INTERVIEWER (Name of person conducting interview)

45. SOURCE OF REFERENCE (Name of person who referred you)

46. DATE OF REFERENCE (Month, day, year)

47. REASON FOR REFERENCE (Why were you referred?)

48. DATE OF REFERENCE (Month, day, year)

49. ADDRESS (Street, city, state, zip)

50. PHONE NUMBER (Area code, number)

51. EMPLOYER (Name of company or organization)

52. SOCIAL SECURITY NUMBER (If any)

53. DATE OF INTERVIEW (Month, day, year)

54. INTERVIEWER (Name of person conducting interview)

55. SOURCE OF REFERENCE (Name of person who referred you)

56. DATE OF REFERENCE (Month, day, year)

57. REASON FOR REFERENCE (Why were you referred?)

58. DATE OF REFERENCE (Month, day, year)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02638

2652

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3018 Hiss Avenue</b>				d. STREET ADDRESS <b>6513 Harford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. David J. Smith</b>			4. DATE OF DEATH <b>March 20th 1956</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1876</b>		9. AGE (In years last birthday) <b>79 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>Ann</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-01-5360</b>		17. INFORMANT <b>Mr. Henry Smith, 3018 Hiss Avenue #14</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL DEGENERATION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY OCCLUSION (1941)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1956</b> , to <b>March 21, 1956</b> , that I last saw the deceased alive on <b>March 10, 1956</b> , and that death occurred at <b>11A M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G.M. Bacon</b>		ADDRESS (Street, city or town, state) <b>2810 TAYLOR-BALTO. 143/145</b>					
PHYSICIAN'S NAME (Type) <b>A.M. BACON</b>		DATE SIGNED <b>3/21/56</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				24a. REC'D BY REGISTRAR <b>DATE 3/21/56</b>		24b. REGISTRAR'S SIGNATURE <b>G.M. Bacon</b>	



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BUREAU V. S.

MAR 22 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02639

2653

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		3801.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Homes of Md.</u>				STREET ADDRESS <u>716 N. Broadway</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Katie</u> (First) <u>Sneed</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>3</u> (Day) <u>30</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>divorced</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 7, 1874</u>	<b>9. AGE last birthday</b> <u>81</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>David Drohan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Roche</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT'S ADDRESS</b> <u>Frank L. Smith Jr. Cockeysville Md.</u>		
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<u>8 M.O.S.</u>	
<b>19a. IMMEDIATE CAUSE</b> (A) <u>Cancer - Abdominal</u>							
<b>19b. ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B)							
<b>STATING UNDERLYING CAUSE LAST, DUE TO</b> (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>			<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>1946</u>, 19....., to <u>3/30</u>, 19<u>56</u>, that I last saw the deceased alive on <u>3/30</u>, 19<u>56</u>, and that death occurred at <u>12:50 P.</u>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Katherine T. Kus</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Cockeysville Md</u>		<b>DATE SIGNED</b> <u>3/30/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>Apr 2-1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Stree</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Frank L. Smith Jr</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm Gork Inc -</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore Md</u>	
<b>DATE</b> <u>APR 3 1956</u>				<b>ADDRESS</b> <u>1217 St Paul St</u>			

# CERTIFICATE OF DEATH

Reg. Form No. 1

1. Name (Last, first, middle initial) \_\_\_\_\_

2. Date of birth \_\_\_\_\_

3. Sex Male _____ Female _____	4. Race White _____ Negro _____ Other _____	5. Usual residence City _____ County _____ State _____
--------------------------------------	--	---

6. Date of death _____	7. Place of death Home _____ Hospital _____ Other _____
------------------------	--

8. Cause of death (Immediate)	9. Cause of death (Underlying)
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10. Duration of illness	11. Period of gestation (if infant)
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12. Signature of physician	13. Signature of registrar
----------------------------	----------------------------

14. Date of registration	15. Registrar's name
--------------------------	----------------------

16. Date of filing	17. Filing number
--------------------	-------------------

18. Date of death	19. Date of registration
-------------------	--------------------------

20. Date of filing	21. Filing number
--------------------	-------------------

22. Date of death	23. Date of registration
-------------------	--------------------------

24. Date of filing	25. Filing number
--------------------	-------------------

26. Date of death	27. Date of registration
-------------------	--------------------------

28. Date of filing	29. Filing number
--------------------	-------------------

30. Date of death	31. Date of registration
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BUREAU V. S.

APR 3 1956

RECEIVED

ENCLOSURE

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

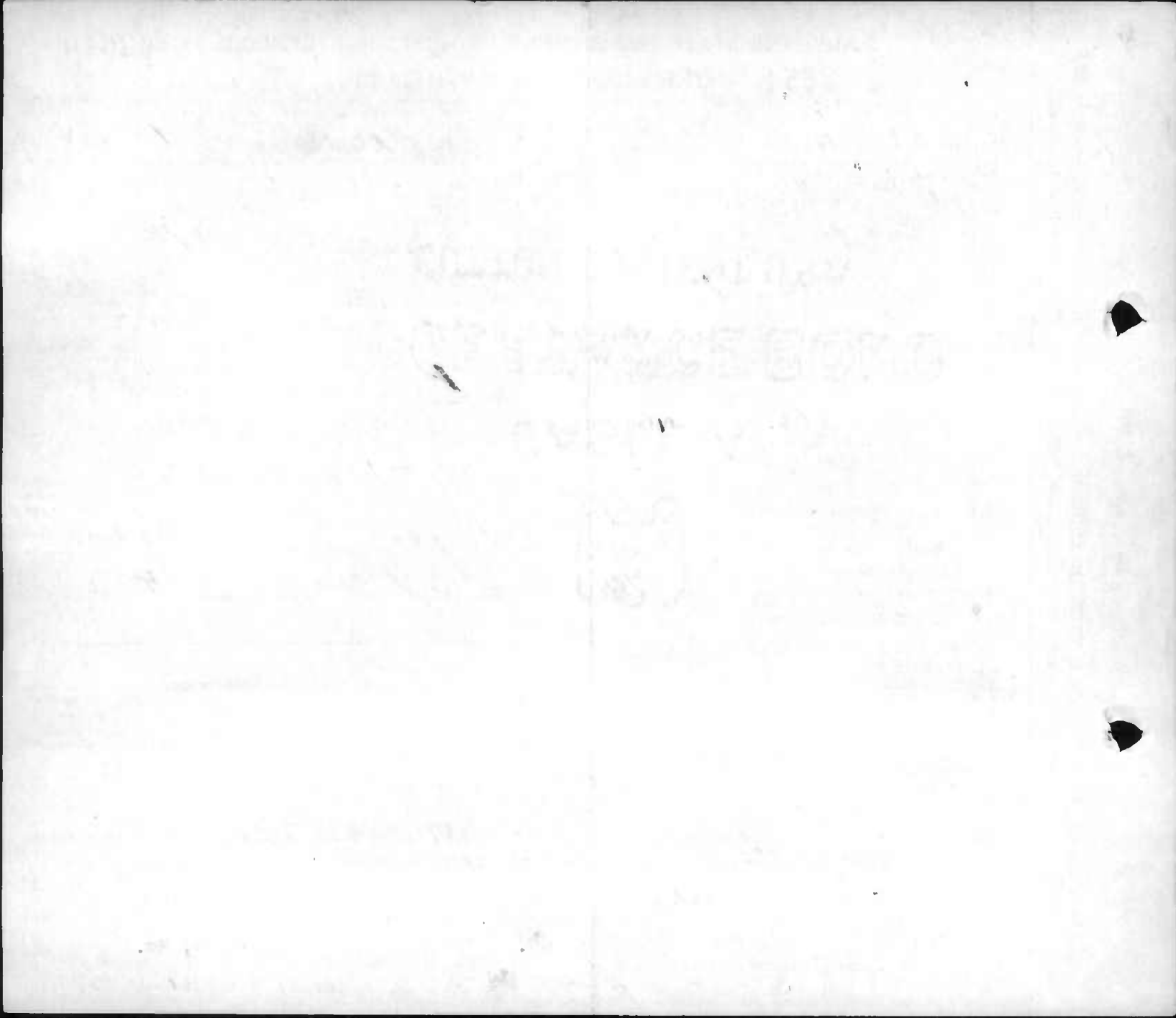
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02640

2654

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE CITY</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>RURAL VILLANOVA</u>		LENGTH OF STAY (in this place) <u>20 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>		<u>3401-4</u>	
HOSPITAL OR ROBB NURSING HOME				STREET ADDRESS (If rural give location) <u>5 W. FORT AVE</u>			
INSTITUTION OR STREET ADDRESS <u>4105 ESSEX RD. BALTIMORE</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>HATTIE DORA SNYDER</u>				OF DEATH: <u>3</u> <u>13</u> <u>1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>JAN. 18, 1878</u>	
				9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOHN HENRY MACIE</u>				14. MOTHER'S MAIDEN NAME: <u>REBECCA ZIMMERMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>AT</u>		17. INFORMANT & ADDRESS: <u>SON - Wm. H. SNYDER.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebral Apoplexy</u>						<u>2 days</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. Disease</u>						<u>50 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>54</u> to <u>March 13</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edwin J. Peirson</u>				ADDRESS <u>8704 Liberty Rd, Balto, Md</u>		DATE SIGNED <u>3/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Cem.</u>		LOCATION (City, town, or county) (State) <u>Loganville, Md. Penna. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>B-7x-56</u>		REGISTRAR'S SIGNATURE <u>Edwin J. Peirson</u>		24. FUNERAL DIRECTOR <u>Wm. J. Teleney</u>		ADDRESS <u>Sons-Balto 17 A</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02641

## 2655 CERTIFICATE OF DEATH

Reg. Dist. No. 37

Item 2, Film G194 4-2-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto.</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>		3 Vol-4	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Lutherville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		Baltimore 12, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>		STREET ADDRESS <u>College Manor 106 Croydon Road</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>JOHN PAUL SNYDER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Mar. 20, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 30, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consultant (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmaceutical</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Anna C. Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. John M. Snyder-106 Croydon Rd.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
527.1 IMMEDIATE CAUSE (A) <u>Pulmonary insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Emphysema</u>				<u>Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-17-56</u> to <u>5-17-56</u> , that I last saw the deceased alive on <u>3-17-56</u> , and that death occurred at <u>6:45</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>William F. Juli</u>				ADDRESS (Street, city, town, state) <u>Washington, D. C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-removal</u>		DATE THEREOF <u>3/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR <u>22 1956</u>		REGISTRAR'S SIGNATURE <u>Anne MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens &amp; Sons - Balto</u>		ADDRESS <u>17th</u>	

# CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

DATE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. A.

MAR 23 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02642

2656

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH: Baltimore  
County.....  
City or town..... Howardville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 63 Years  
Hospital, institution, or street address where death occurred:  
Campfield Road  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Baltimore  
City or town..... Howardville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Campfield Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... None

3. (a) FULL NAME  
MUSADORA SNYDER

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife xx Henry G. Snyder  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) March, 27th. 1873  
8. AGE: Years 82 Months 11 Days 20 If less than one day..... hrs. .... min.

9. Birthplace..... Winfield, Maryland  
(Town, county, and state)  
10. Usual occupation..... Housewife  
11. Industry or business..... At home

12. Name..... Price Criswell  
13. Birthplace.....  
14. Maiden name..... Susana Hoffman  
15. Birthplace.....

16. Informant..... Mrs Katherine Bowling  
Address..... Campfield Road, Howardville

17. Burial..... March, 21<sup>st</sup> 1956  
(Burial, cremation, or removal, Which?) Date thereof..... (month) (day) (year)  
Cemetery or crematory..... Mt. Olive Cemetery  
Location..... Randallstown, Maryland.

18. Funeral director..... Willis Lawrence  
Address..... 4510 Liberty Heights Ave.

19. 3/20 19 56  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... March, 18th 19 56 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 53 to March 18<sup>th</sup> 19 56  
and that I last saw h.e.r. alive on March 18<sup>th</sup> 19 56

Immediate cause of death..... uremia DURATION 2 wks

Due to..... Chronic Nephritis 2 yrs.

Due to..... Art. Sclerosis 3 yrs.

Other conditions..... Hypertension 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... James G. Miller

Registerstown Rd. & Walker Ave. Mar. 19<sup>th</sup> 1956

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18.7.52

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



2657

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>✓</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Dwyn Oak</i>		<i>8 yrs</i>		OR TOWN <i>Balto</i>		<i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hugsburg Home</i>				STREET ADDRESS (If rural give location) <i>2002 E. Lafayette Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Lizette</i> <i>Somelborn</i>				<i>3/27</i> <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <i>Widow</i>	8. DATE OF BIRTH: <i>Apr 12, 1873</i>	9. AGE last birthday <i>82</i> yrs	10. UNDER 1 YEAR	11. UNDER 24 HRS	12. UNDER 48 HRS
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country): <i>Balto md</i>	
13. FATHER'S NAME: <i>Henry Weller</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Frank</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>—</i> (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
170X	(A) IMMEDIATE CAUSE	<i>6 months</i>
	(B) ANTECEDENT CAUSE (S)	<i>5 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
(C) <i>Barcinoma (G.I. tract.)</i>		
<i>- Anterio-sclerotic Heart Disease</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<i>- Chronic Gall Bladder</i>		<i>- 6 yrs.</i>

19A. DATE OF OPERATION: <i>- Dec. - 1951 -</i>	19B. MAJOR FINDINGS OF OPERATION: <i>- Rt. Breast - Removed (Cancer)</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *5/10*, 1949, to *3/27*, 1956, that I last saw the deceased alive on *3/22*, 1956, and that death occurred at *9 A.M.* from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/29/56</i>	NAME OF CEMETERY OR CREMATORY <i>Western Bur</i>	LOCATION (City, town, or county) <i>Balto</i>	DATE SIGNED <i>3/27/56</i>	ADDRESS <i>6007 Hartford Rd</i>
DATE REC'D BY LOCAL REGISTRAR <i>3/29/56</i>		REGISTRAR'S SIGNATURE <i>AW Neffrich</i>		FUNERAL DIRECTOR <i>Paula Neumann</i>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL

148-  
1873  
83

2658

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1508 Midvale Ave</b>				d. STREET ADDRESS <b>1508 Midvale Ave</b>			
3. NAME OF DECEASED (Type or print) <b>MINNIE - LOUISE - STANDIFORD</b>				4. DATE OF DEATH <b>March 26 1956</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV-3-1880</b>	
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>KENT CO - MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Sewell</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Rash</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <b>420.0</b>		17. INFORMANT <b>Sara R. Davis</b> Address <b>1508 Midvale Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Oct. 19 49</b> , to <b>March 19 56</b> , that I last saw the deceased alive on <b>March 25 19 56</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Baltimore, Md.</b> DATE SIGNED <b>3/26/56</b>							
ACTUAL SIGNATURE <b>L. J. Gaver</b> M.D. <b>1 Mallow Hill Ave., Baltimore, Md.</b>							
PHYSICIAN'S NAME (Type) <b>LEO J. GAVEL</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 29 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Balto Md</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Penfel</b> ADDRESS <b>5311 Edmondson Ave</b>				24a. REC'D BY REGISTRAR <b>DATE 27 1956</b>		24b. REGISTRAR'S SIGNATURE <b>V. E. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

2838

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Register No.

DEATH NUMBER (For use by the Registrar)

FILE NO.

DEATH DATE

DEATH TIME

DEATH PLACE

DEATH CAUSE

DEATH PLACE

DEATH TIME

DEATH PLACE

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BUREAU V. S.

MAR 27 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2659

## CERTIFICATE OF DEATH

Reg. Dist. No.

02645  
30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>				c. LENGTH OF STAY IN 1b <b>26yr. 2mos. 4days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>14 Spring Grove State Hospital</b>				e. STREET ADDRESS <b>819 E. Pratt Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>WILADYSLAW</b> Last <b>Stefanawich</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>		13. FATHER'S NAME <b>Napoleon Stefanawich</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never, unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-3-</b> , 19 <b>29</b> , to <b>3-7-</b> , 19 <b>56</b> that I last saw the deceased alive on <b>3-7-</b> , 19 <b>56</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. Glyne Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b> DATE SIGNED <b>3-7-56</b>			
PHYSICIAN'S NAME (Type) <b>T. Glyne Williams, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Ozagowski</b> ADDRESS <b>1930 Eastern Ave.</b>				24a. REC'D BY REGISTRAR <b>8</b> DATE <b>1956</b>		24b. REGISTRAR'S SIGNATURE <b>T. E. Harry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status		Date of Death		Time of Death		Place of Death		Physician		Hospital		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
John Doe		Male		45		Jan 1, 1900		New York		New York		Heart Disease		Natural		Teacher		High School		Catholic		Married		Jan 15, 1945		10:00 AM		New York		St. John's Hospital		St. John's Cemetery		Jan 15, 1945		10:00 AM		St. John's Cemetery		Jan 15, 1945		10:00 AM			

BUREAU V. S.

MAR 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2660

## CERTIFICATE OF DEATH

02646

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Belinda Ave.</b>				d. STREET ADDRESS <b>3 Belinda Ave.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward H. Stegman</b>				4. DATE OF DEATH Month Day Year <b>March 8 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1894</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Conrad Stegman</b>				14. MOTHER'S MAIDEN NAME <b>Anna Blanke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-16-0214</b>		17. INFORMANT Address <b>Mrs. Albert Alms-3 Belinda Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma &amp; Hypoproteinemia Severe</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ascites and drainage.</b> DUE TO (c) <b>Portal Cirrhosis, hemorrhagic type Severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>3.4 wks.</b> <b>?</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Exploratory laparotomy By Dr Camp at Union Memorial Hosp East. Corridor</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>3 Mar. 1956</b> , to <b>8 Mar. 1956</b> , that I last saw the deceased alive on <b>7 Mar. 1956</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John C. Hyle</b>				ADDRESS (Street, city or town, state) <b>7527 Belair Rd Baltimore 3956</b>			
PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>				M.D. <b>7527 Belair Rd Baltimore 3956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanahn Funeral Home</b>				ADDRESS <b>7401 Belair Rd</b>		24. REC'D BY REGISTRAR DATE <b>MAR 12 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. L. L. Reifman</b>			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02647  
30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Edward</b> Last <b>Stevens</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1868</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months <b>87</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Fuller E. Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cauritt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Records: Spring Grove State Hospital</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioaclarotic Cardiovascular Disease</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.7 <b>Fracture left femur</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on hospital ward</b>	
20c. TIME OF INJURY Month, Day, Year <b>Mar 20 1956</b> Hour <b>9</b> a. m. <b>2:30</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital Ward</b>		20f. (City or town) (County) (State) <b>Catonsville Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George S. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George S. M. Kieffer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>3/31/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 3, 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davidsonville Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Davidsonville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>ANNAPOLIS, MD.</b>	
24a. REC'D BY REGISTRAR <b>APR 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>J. C. Harry</b>	



2851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth	
John J. Smith		Male		45		1910	
Place of Birth		Cause of Death		Manner of Death		Occupation	
New York City		Heart Disease		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician	
April 2, 1956		10:30 AM		Home		Dr. J. H. Jones	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. H. Jones		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 3 1956

RECEIVED

*Handwritten signature/initials*

XXXX



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G195 4-6-56 at

2662

## CERTIFICATE OF DEATH

Reg. Dist. No.

02648

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>174 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Coombs</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 21, 1882</b>	
9. AGE (In years last birthday) <b>73 7/8</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Garage</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Tone A. Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Laura V. Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Sept 22, 1955</b> to <b>Mar 22, 1956</b> that I last saw the deceased alive on <b>Mar 22, 1956</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.				ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>WILLIAM NEWCOMER, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>3/25/56</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Maxwell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2023

<p>1. NAME OF DECEASED                  Mr. Wilson                  2. PLACE OF DEATH                  Wilson's Hospital</p>		<p>3. SEX                  Male</p>		<p>4. AGE                  65</p>	
<p>5. OCCUPATION                  None</p>		<p>6. MARITAL STATUS                  Married</p>		<p>7. DATE OF BIRTH                  1958</p>	
<p>8. CAUSE OF DEATH                  Heart Disease</p>		<p>9. MANNER OF DEATH                  Natural</p>		<p>10. PLACE OF BIRTH                  Baltimore, Md.</p>	
<p>11. SIGNATURE OF PHYSICIAN                  J. Wilson</p>		<p>12. SIGNATURE OF REGISTRAR                  J. Wilson</p>		<p>13. DATE OF DEATH                  1958</p>	
<p>14. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>15. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>16. DATE OF DEATH                  1958</p>	
<p>17. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>18. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>19. DATE OF DEATH                  1958</p>	
<p>20. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>21. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>22. DATE OF DEATH                  1958</p>	
<p>23. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>24. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>25. DATE OF DEATH                  1958</p>	
<p>26. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>27. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>28. DATE OF DEATH                  1958</p>	
<p>29. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>30. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>31. DATE OF DEATH                  1958</p>	
<p>32. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>33. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>34. DATE OF DEATH                  1958</p>	
<p>35. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>36. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>37. DATE OF DEATH                  1958</p>	
<p>38. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>39. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>40. DATE OF DEATH                  1958</p>	
<p>41. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>42. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>43. DATE OF DEATH                  1958</p>	
<p>44. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>45. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>46. DATE OF DEATH                  1958</p>	
<p>47. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>48. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>49. DATE OF DEATH                  1958</p>	
<p>50. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>51. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>52. DATE OF DEATH                  1958</p>	
<p>53. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>54. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>55. DATE OF DEATH                  1958</p>	
<p>56. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>57. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>58. DATE OF DEATH                  1958</p>	
<p>59. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>60. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>61. DATE OF DEATH                  1958</p>	
<p>62. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>63. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>64. DATE OF DEATH                  1958</p>	
<p>65. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>66. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>67. DATE OF DEATH                  1958</p>	
<p>68. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>69. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>70. DATE OF DEATH                  1958</p>	
<p>69. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>70. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>71. DATE OF DEATH                  1958</p>	
<p>70. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>71. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>72. DATE OF DEATH                  1958</p>	
<p>71. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>72. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>73. DATE OF DEATH                  1958</p>	
<p>72. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>73. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>74. DATE OF DEATH                  1958</p>	
<p>73. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>74. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>75. DATE OF DEATH                  1958</p>	
<p>74. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>75. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>76. DATE OF DEATH                  1958</p>	
<p>75. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>76. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>77. DATE OF DEATH                  1958</p>	
<p>76. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>77. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>78. DATE OF DEATH                  1958</p>	
<p>77. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>78. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>79. DATE OF DEATH                  1958</p>	
<p>78. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>79. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>80. DATE OF DEATH                  1958</p>	
<p>79. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>80. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>81. DATE OF DEATH                  1958</p>	
<p>80. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>81. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>82. DATE OF DEATH                  1958</p>	
<p>81. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>82. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>83. DATE OF DEATH                  1958</p>	
<p>82. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>83. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>84. DATE OF DEATH                  1958</p>	
<p>83. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>84. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>85. DATE OF DEATH                  1958</p>	
<p>84. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>85. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>86. DATE OF DEATH                  1958</p>	
<p>85. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>86. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>87. DATE OF DEATH                  1958</p>	
<p>86. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>87. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>88. DATE OF DEATH                  1958</p>	
<p>87. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>88. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>89. DATE OF DEATH                  1958</p>	
<p>88. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>89. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>90. DATE OF DEATH                  1958</p>	
<p>89. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>90. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>91. DATE OF DEATH                  1958</p>	
<p>90. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>91. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>92. DATE OF DEATH                  1958</p>	
<p>91. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>92. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>93. DATE OF DEATH                  1958</p>	
<p>92. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>93. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>94. DATE OF DEATH                  1958</p>	
<p>93. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>94. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>95. DATE OF DEATH                  1958</p>	
<p>94. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>95. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>96. DATE OF DEATH                  1958</p>	
<p>95. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>96. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>97. DATE OF DEATH                  1958</p>	
<p>96. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>97. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>98. DATE OF DEATH                  1958</p>	
<p>97. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>98. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>99. DATE OF DEATH                  1958</p>	
<p>98. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>99. SIGNATURE OF WITNESS                  J. Wilson</p>		<p>100. DATE OF DEATH                  1958</p>	

BUREAU V. S.

MAR 29 1956

RECEIVED

# TOWSON STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02649

Items 8,9, Film G191 3-27-56 et

2663

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Nursing Home</b> <b>Bosely and Chesapeake Ave.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3504 Ailsa Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mr. George W. Streat</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>19th</b> Year <b>1956</b>																			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 22, 1869 ?</b>																	
<b>9. AGE</b> (In years last birthday) <b>88</b> yrs. <table border="1" style="float: right; margin-top: -20px;"> <tr> <th colspan="4">IF UNDER 1 YEAR</th> <th colspan="4">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				IF UNDER 1 YEAR				IF UNDER 24 HRS.				Months	Days	Hours	Min.					<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Candler Building</b>			
IF UNDER 1 YEAR				IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																				
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired Candler Building</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Nanticoke, Maryland</b>																			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>MSA</b>				<b>13. FATHER'S NAME</b> <b>?</b>																			
<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)																			
<b>16. SOCIAL SECURITY NO.</b> <b>218-09-3014</b>				<b>17. INFORMANT</b> Address <b>Mr. William J. Streat, 1116 S. Alfred Street</b>																			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensative Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____																							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)																	
<b>20f. (City or town)</b> (County) (State)				<b>21. I certify that I attended the deceased from</b> <u>March 15, 1956</u> , to <u>March 18, 1956</u> , that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.																			
<b>ACTUAL SIGNATURE</b> <u>Laurence C. Post M.D.</u> M.D. <u>6805 York Rd.</u> ADDRESS (Street, city or town, state) DATE SIGNED _____				<b>PHYSICIAN'S NAME (Type)</b> <u>LAURENCE C. Post</u> <u>Maryland</u>																			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>3/22/1956</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial Park</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Maryland</b>																	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Leonard J. Ruck, 5305 Harford Road #14</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>22 1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Mabel Gray</u>																	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

Name of Deceased Tolson, John		Sex Male		Age 70	
Date of Death April 10, 1955		Place of Death Baltimore, Md.		Cause of Death Heart Disease	
Manner of Death Natural		Occupation Teacher		Usual Residence Baltimore, Md.	
Signature of Physician [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]	
Date of Report April 15, 1955		Place of Report Baltimore, Md.		Name of Reporting Agency Baltimore Health Department	

BUREAU V. S.

MAR 22 1955

RECEIVED

2664

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadena</u> <u>026-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Shady Nook Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Mountain Rd.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MAE BERFIELD SWETLAND</u>				<u>Mar. 13, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>May 24, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>-</u>				<u>Penna.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Francis Marion Berfield</u>				<u>Almina Nelson Berfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>-</u>						<u>Md.</u> <u>Mr. C. B. Nairn - Mountain Rd., Pasadena</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
446X IMMEDIATE CAUSE			(A) <u>Pneumo-pneumonia</u>				<u>1 Week</u>
ANTECEDENT CAUSE (S):			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) <u>Hypertension</u>				<u>Year</u>
			DUE TO				
			(C) <u>arterio sclerosis</u>				<u>Year</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>3/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. Zimmerman</u>			ADDRESS <u>M. D. 1118 St. Paul St - Balto.</u>		DATE SIGNED <u>3/14/56</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, of county) (State)
<u>Removal</u>			<u>3/15/56</u>		<u>Eulalia</u>		<u>Coudersport, Penna.</u>
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS		
<u>3-18-56</u>			<u>H. N. Kellum</u>		<u>Wm. J. Lickner &amp; Sons - Balto.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02651  
74

Reg. Dist. No.

2665

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>80 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BRIGHT E. THARPE</b>				4. DATE OF DEATH Month Day Year <b>March 23 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 26, 1892</b>	
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rock County, Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles Tharpe</b>				14. MOTHER'S MAIDEN NAME <b>Tony Lamb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>263-22-2057</b>			
17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED DUODENAL ULCER WITH GENERALIZED PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>541.1</b> (c) <b>UNKNOWN</b> DUE TO (b) <b>UNKNOWN</b> (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchogenic Carcinoma, Left Lung</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 3, 1956</b> , to <b>March 23, 1956</b> , and that death occurred at <b>8:08 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3-23-56</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 11, Md.</b>							
24a. REC'D BY REGISTRAR <b>MAR 27 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lasker</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02652  
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen L. Martin Plant Hospital</u>				d. STREET ADDRESS <u>11 N. Streeper St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Marion Theisz Sr.</u>				4. DATE OF DEATH Month Day Year <u>March 19 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1907</u>	
9. AGE (in years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stockkeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Theisz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Aires</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-2101</u>		17. INFORMANT Address <u>Mrs. Louise Theisz 11 N. Streeper St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dabrowski</u>				ADDRESS <u>2818 E. Baltimore St.</u>		24. REC'D BY REGISTRAR <u>March 21, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>		DATE SIGNED <u>3/21/56</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH	
8. OCCUPATION		9. MARITAL STATUS		10. EDUCATION		11. BIRTH DATE		12. BIRTH PLACE		13. PREVIOUS ILLNESS		14. CAUSE OF DEATH	
15. MANNER OF DEATH		16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE		21. SIGNATURE OF CLERK	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF PRIEST		25. SIGNATURE OF MINISTER		26. SIGNATURE OF RABBI		27. SIGNATURE OF CHAPLAIN		28. SIGNATURE OF OTHER	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN		31. SIGNATURE OF PRIEST		32. SIGNATURE OF MINISTER		33. SIGNATURE OF RABBI		34. SIGNATURE OF CHAPLAIN		35. SIGNATURE OF OTHER	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF PRIEST		39. SIGNATURE OF MINISTER		40. SIGNATURE OF RABBI		41. SIGNATURE OF CHAPLAIN		42. SIGNATURE OF OTHER	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF PRIEST		46. SIGNATURE OF MINISTER		47. SIGNATURE OF RABBI		48. SIGNATURE OF CHAPLAIN		49. SIGNATURE OF OTHER	
50. SIGNATURE OF DECEASED		51. SIGNATURE OF NEXT OF KIN		52. SIGNATURE OF PRIEST		53. SIGNATURE OF MINISTER		54. SIGNATURE OF RABBI		55. SIGNATURE OF CHAPLAIN		56. SIGNATURE OF OTHER	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF PRIEST		60. SIGNATURE OF MINISTER		61. SIGNATURE OF RABBI		62. SIGNATURE OF CHAPLAIN		63. SIGNATURE OF OTHER	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF NEXT OF KIN		66. SIGNATURE OF PRIEST		67. SIGNATURE OF MINISTER		68. SIGNATURE OF RABBI		69. SIGNATURE OF CHAPLAIN		70. SIGNATURE OF OTHER	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF PRIEST		74. SIGNATURE OF MINISTER		75. SIGNATURE OF RABBI		76. SIGNATURE OF CHAPLAIN		77. SIGNATURE OF OTHER	
78. SIGNATURE OF DECEASED		79. SIGNATURE OF NEXT OF KIN		80. SIGNATURE OF PRIEST		81. SIGNATURE OF MINISTER		82. SIGNATURE OF RABBI		83. SIGNATURE OF CHAPLAIN		84. SIGNATURE OF OTHER	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF PRIEST		88. SIGNATURE OF MINISTER		89. SIGNATURE OF RABBI		90. SIGNATURE OF CHAPLAIN		91. SIGNATURE OF OTHER	
92. SIGNATURE OF DECEASED		93. SIGNATURE OF NEXT OF KIN		94. SIGNATURE OF PRIEST		95. SIGNATURE OF MINISTER		96. SIGNATURE OF RABBI		97. SIGNATURE OF CHAPLAIN		98. SIGNATURE OF OTHER	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF NEXT OF KIN		101. SIGNATURE OF PRIEST		102. SIGNATURE OF MINISTER		103. SIGNATURE OF RABBI		104. SIGNATURE OF CHAPLAIN		105. SIGNATURE OF OTHER	

BUREAU V. S.

MAR 22 1956

RECEIVED

02653

## CERTIFICATE OF DEATH

2667

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Ma.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Catonsville</u>				OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u> <u>Paradise Ave. &amp; Altamont Rd</u>				STREET ADDRESS (If rural give location) <u>515 Rock Glen Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sophia F. Tinley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 3/56</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>June 4, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Heinrich Cran</u>				14. MOTHER'S MAIDEN NAME <u>Florentina Bruckmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Arthur Gladmon, 515 Rock Glen Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <u>Pneumonia, bilateral (Broncho-pneumonia)</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardio-vascular Disease</u>						5 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 51</u> , to <u>March 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Md 1 Mallow Hill Ave., Baltimore 29, Md</u>		DATE SIGNED <u>3/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Mar. 7, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>101 Edmondson Ave</u>	

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M



# CERTIFICATE OF DEATH

NEW YORK

2003

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BURIAL

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF MAYOR

19. SIGNATURE OF COMMISSIONER

20. SIGNATURE OF GOVERNOR

21. SIGNATURE OF SENATE

22. SIGNATURE OF ASSEMBLY

23. SIGNATURE OF COURTS

24. SIGNATURE OF JURY

25. SIGNATURE OF GRAND JURY

26. SIGNATURE OF DISTRICT ATTORNEY

27. SIGNATURE OF COUNTY CLERK

28. SIGNATURE OF CITY CLERK

29. SIGNATURE OF VICE MAYOR

30. SIGNATURE OF ALDERMAN

31. SIGNATURE OF COMMON COUNCIL

32. SIGNATURE OF BOARD OF HEALTH

33. SIGNATURE OF BOARD OF EDUCATION

34. SIGNATURE OF BOARD OF CHARITIES

35. SIGNATURE OF BOARD OF ALMS

36. SIGNATURE OF BOARD OF PRISONS

37. SIGNATURE OF BOARD OF LUNATICS

38. SIGNATURE OF BOARD OF SCHOOLS

39. SIGNATURE OF BOARD OF AGENCIES

40. SIGNATURE OF BOARD OF COMMISSIONERS

41. SIGNATURE OF BOARD OF SUPERVISORS

42. SIGNATURE OF BOARD OF EXAMINERS

43. SIGNATURE OF BOARD OF APPEALS

44. SIGNATURE OF BOARD OF REVIEW

45. SIGNATURE OF BOARD OF COUNSEL

46. SIGNATURE OF BOARD OF ADVISORS

47. SIGNATURE OF BOARD OF CONSULTANTS

48. SIGNATURE OF BOARD OF INVESTIGATORS

49. SIGNATURE OF BOARD OF RESEARCHERS

50. SIGNATURE OF BOARD OF STUDENTS

51. SIGNATURE OF BOARD OF FACULTY

52. SIGNATURE OF BOARD OF ADMINISTRATION

53. SIGNATURE OF BOARD OF MANAGEMENT

54. SIGNATURE OF BOARD OF FINANCE

55. SIGNATURE OF BOARD OF OPERATIONS

56. SIGNATURE OF BOARD OF LOGISTICS

57. SIGNATURE OF BOARD OF SUPPLY

58. SIGNATURE OF BOARD OF DISTRIBUTION

59. SIGNATURE OF BOARD OF MAINTENANCE

60. SIGNATURE OF BOARD OF REPAIRS

61. SIGNATURE OF BOARD OF UPGRADES

62. SIGNATURE OF BOARD OF MODIFICATIONS

63. SIGNATURE OF BOARD OF ALTERATIONS

64. SIGNATURE OF BOARD OF ADDITIONS

65. SIGNATURE OF BOARD OF SUBTRACTIONS

66. SIGNATURE OF BOARD OF RECONSTRUCTIONS

67. SIGNATURE OF BOARD OF RESTORATIONS

68. SIGNATURE OF BOARD OF PRESERVATIONS

69. SIGNATURE OF BOARD OF PROTECTIONS

70. SIGNATURE OF BOARD OF DEFENSES

71. SIGNATURE OF BOARD OF OFFENSES

72. SIGNATURE OF BOARD OF VIOLATIONS

73. SIGNATURE OF BOARD OF INFRINGEMENTS

74. SIGNATURE OF BOARD OF BREACHES

75. SIGNATURE OF BOARD OF MISFEASANCES

76. SIGNATURE OF BOARD OF NONFEASANCES

77. SIGNATURE OF BOARD OF TRESPASSES

78. SIGNATURE OF BOARD OF NUISANCES

79. SIGNATURE OF BOARD OF OBSTRUCTIONS

80. SIGNATURE OF BOARD OF ENCUMBRANCES

81. SIGNATURE OF BOARD OF INTERFERENCE

82. SIGNATURE OF BOARD OF HINDERANCES

83. SIGNATURE OF BOARD OF OBSTACLES

84. SIGNATURE OF BOARD OF IMPEDIMENTS

85. SIGNATURE OF BOARD OF HURDLES

86. SIGNATURE OF BOARD OF BARRIERS

RECEIVED  
MAR 2 1956  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2668

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02654

No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Reisterstown</b>		LENGTH OF STAY (in this place) <b>35 yrs</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Reisterstown</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Glen Falls Road</b>				STREET ADDRESS (If rural, give location) <b>Glen Falls Road</b>			
3. NAME OF DECEASED: (Type or Print) <b>Charles L. Uhler</b>				4. DATE OF DEATH <b>March 19, 1956</b> 19			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>Sept. 22, 1872</b>	
9. AGE last birthday: <b>83 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY: <b>Farmer</b>		11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Farmer</b>			
13. FATHER'S NAME: <b>Charles W. Uhler</b>				14. MOTHER'S MAIDEN NAME: <b>Sallie A. Lorey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Mrs. Maggie Uhler, Reisterstown, Md.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<b>420.1</b> <b>Immediate cause</b> (a) <b>Coronary Artery Disease</b> DUE TO <b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							<b>3 hrs.</b>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>							
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION: <b>none</b>					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b> <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>none</b>		21c. (City or town) (County) (State) <b>none</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b> M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <b>3-20-56</b>					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF: <b>Mar. 22, 1956</b>		NAME OF CEMETERY OR CREMATORY: <b>Finksburg</b>		LOCATION (City, town, or county) (State): <b>Carroll County</b>	
DATE REC'D BY LOCAL REG. <b>3-20-56</b>		REGISTRAR'S SIGNATURE: <b>Mary B. Zline</b>		24. FUNERAL DIRECTOR: <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	

BUREAU V. 1

MAR 22 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02655

## 2659 CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>Baltimore - 12</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL or give nearest town) <b>Baltimore - 12</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>500 Murdock Rd.</b>				STREET ADDRESS (If rural give location) <b>500 Murdock Rd. Zone 12</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>ANGELO</b> (First) <b>VICARI</b> (Middle) (Last)				<b>4. DATE OF DEATH</b> <b>Mar. 28,</b> 19 <b>56</b> (Month) (Day) (Year)			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>April 20, 1874</b>	<b>9. AGE last birthday</b> <b>81</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Commission Merchant - Fruit</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>Michael Vicari</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rose Jeroshi</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. R. Louise Vicari-500 Murdock Rd.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>541.0 IMMEDIATE CAUSE (A)</b> <b>Gastro Intestinal Hemorrhage - Duodenal Ulcer</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 10, 1945, to March 28, 1956, that I last saw the deceased alive on March 28, 1956, and that death occurred at 8 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Lawrence C. Posh</b>		<b>DATE THEREOF</b> <b>3/31/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Western Cem.</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Balto., Md.</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REC'D BY REGISTRAR</b> <b>APR 3 1956</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. J. Pickney &amp; Sons - Balto</b>		<b>DATE SIGNED</b> <b>3-29-56</b>	

RECEIVED

Item 13, Film 1954-12-56 et

2670

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	STATE <b>Md</b> COUNTY <b>BALTO</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>NO 1 CLEARWOOD RD</b>	LENGTH OF STAY (in this place) <b>2 yrs</b>	STREET ADDRESS (If rural give location) <b>1501 CLEARWOOD RD</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>VINCENT IGNATIUS WALTER</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>March 28 1956</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH: <b>FEB 14-1890</b>
9. AGE last birthday <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if not now) <b>MACHINIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Boiler Works</b>	
11. BIRTHPLACE (State or foreign country): <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Vincent Ignatius Walter, Sr.</b>		14. MOTHER'S MAIDEN NAME: <b>MARIE GALLAGHER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>718-01-8110</b>	
17. INFORMANT'S ADDRESS: <b>MARY F. GILLIS 1501 CLEARWOOD RD</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Carcinoma of Pancreas</b>			<b>8-10</b>
ANTECEDENT CAUSE (S) (B) <b>and metastasis to liver and intestines</b>			<b>months</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>and intestines</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>Feb 2, 1956</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Ca. of Pancreas, Liver, Intestines</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August, 1955, to March, 1956, that I last saw the deceased alive on March 28, 1956, and that death occurred at 5 <sup>th</sup> P.M. from the causes and on the date stated above.			
SIGNATURE <b>W. Meredith Smith</b>		DATE SIGNED <b>March 28, 1956</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>3/31/56</b>	
NAME OF CEMETERY OR CREMATORY <b>HORRAINE CEM</b>		LOCATION (City, town, or county) (State) <b>WOODLAWN Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>3/29/56</b>		REGISTRAR'S SIGNATURE <b>W. Meredith Smith</b>	
24. FUNERAL DIRECTOR <b>W. Meredith Smith</b>		ADDRESS <b>6305 The Alameda</b>	

MARGIN RESERVED FOR BINDING

1000

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
SALT LAKE CITY, UTAH

REPORT OF THE  
SALT LAKE CITY WATER RESOURCES DIVISION

ON THE  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION

BY  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION

BY  
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE  
SALT LAKE CITY WATER RESOURCES DIVISION



2671  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <u>ROSEWOOD TRAINING SCHOOL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OWINGS MILLS</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON Md.</u> <u>07-21-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROSEWOOD TRAINING SCHOOL</u>				STREET ADDRESS (If rural give location) <u>REISTERTOWN RD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PAUL LEAOY WARD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MARCH 4 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>S.</u>	8. DATE OF BIRTH: <u>7-12-46</u>	9. AGE last birthday: <u>9</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>ALVIN LEAOY WARD.</u>				14. MOTHER'S MAIDEN NAME: <u>MARIAN WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>HOSPITAL RECORDS.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARDIAC FAILURE.. (ACUTE)</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>SEVERE PNEUMONIA..</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYDROCEPHALY, SECONDARY ANEMIA</u>							
19A. DATE OF OPERATION: <u>NO</u>			19B. MAJOR FINDINGS OF OPERATION: <u>NO</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>5-1, 1952</u> , to <u>3-4, 1956</u> , that I last saw the deceased alive on <u>3-4, 1956</u> , and that death occurred at <u>6:55AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Anable</u>			ADDRESS <u>2920 N. Calvert</u>			DATE SIGNED <u>3-4-56.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>3 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Friends</u>		LOCATION (City, town, or county) (State) <u>Calvert, Cecil Co Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>MAR 6 1956</u>			REGISTRAR'S SIGNATURE <u>Mary Shively</u>			24. FUNERAL DIRECTOR ADDRESS <u>Joseph R. Shaw North East</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1956

RECEIVED

2672

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>39 DAYS</b>		d. STREET ADDRESS <b>231 N. CARLTON STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>(NMI)</b> Last <b>WARDLAW</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-26</b>
9. AGE (In years last birthday) <b>29 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY BUSINESS</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM WARDLAW</b>	
14. MOTHER'S MAIDEN NAME <b>MAGGIE CHILDS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>	
16. SOCIAL SECURITY NO. <b>217-12-6074</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT NEPHROSCLEROSIS</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 YEARS</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>VA</b> attended the deceased from <b>FEB. 12, 1956</b> , to <b>MARCH 22, 1956</b> , that <b>VA</b> attended the deceased alive on <b>18</b> and that death occurred at <b>8:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 3-22-56</b>			
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/26/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Cooper</b>		24a. REC'D BY REGISTRAR <b>Apr. 2, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Lawson L. Parker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 12, Film G194 3-27-56 et  
2673  
CERTIFICATE OF DEATH

02659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3401 Woodbrook Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>NMI</b> Last <b>Weinstein</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Kasanowitz</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Greenberg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SpringGroveStateHospital</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> (b) <b>Myocardial failure</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH hours <b>1 month plus</b> years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of breast with bony and other metastases; diabetes mell.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from **2/16/1956**, to **Mar. 16, 1956**, that I last saw the deceased alive on **March 16, 1956**, and that death occurred at **6:55 PM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED  
**Spring Grove State Hospital 3/17/56**  
ACTUAL SIGNATURE **L. Glyne Williams** M.D.  
PHYSICIAN'S NAME (Type) **T. Glyne Williams, M.D.**

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>3-18-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mishkeno Israel Balto</b>	22d. LOCATION (City, town, or county) (State) <b>md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		24a. REC'D BY REGISTRAR DATE <b>19 1956</b>	
ADDRESS <b>2100 Eutaw Place</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Perry</b>	

1991

BUREAU V. S.

MAR 19 1955

RECEIVED



Items 8,9 Film 6195 4-13-56 et

2517

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MD.</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <b>53 TOWN DUNDALK</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>301-4 TOWN BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2414 Meadow Rd.</b>		STREET ADDRESS (If rural give location) <b>3807 Hudson St.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>DOROTHY MAY WEITZEL</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>March 30, 1956.</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>September 14, 08, ? 48 ?</b> yrs.
9. AGE last birthday		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Press Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>American Can Co.</b>	
11. BIRTHPLACE (State or foreign country): <b>Erwin, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Charles A. Bolyard</b>		14. MOTHER'S MAIDEN NAME: <b>Lillie M. Bishof</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <b>James J. Weitzel, 3807 Hudson St.</b>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <b>170X Malignancy - Carcinoma, breast</b>			<b>3 yr.?</b>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Metastasis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)			
19A. DATE OF OPERATION: <b>Oct. 1954</b>		19B. MAJOR FINDINGS OF OPERATION: <b>Carcinoma, right breast</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>Oct. 1954</b> to <b>Mar. 29, 1956</b> that I last saw the deceased alive on <b>Mar. 26, 1956</b> , and that death occurred at <b>4:45 M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Harry Selmenow</b>		ADDRESS <b>1308 Eutaw Place</b> DATE SIGNED <b>4/2/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>4-2-56</b>	
NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., MD.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>4-2-56</b>		REGISTRAR'S SIGNATURE <b>Wm. Hedrick</b>	
24. FUNERAL DIRECTOR <b>Charles S. Guler</b>		ADDRESS <b>401 S. CONKLING ST. BALTO., MD.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1308 Eutaw Place  
Mr. Harry Kelmenson.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02661

2674

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

Item 9, Film G194 3-22-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Cockeysville</u>		<u>6 years</u>		TOWN <u>Baltimore</u>		<u>3 years</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Masonic Home of Md</u>				STREET ADDRESS (If rural give location) <u>4330 Parkside Dr.</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary E. Whitaker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 11 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. WILLIAM FRAZIER</u>				14. MOTHER'S MAIDEN NAME <u>JULIA L. BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>FRANK L. SMITH JR COCKEYSVILLE MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
493X IMMEDIATE CAUSE (A) <u>Pneumonia</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not white at work <input type="checkbox"/> White at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 14</u> , 19 <u>56</u> , to <u>March 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>56</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kees</u>				DATE SIGNED <u>3/15/56</u>			
M.D.				ADDRESS (Street, city, town, state) <u>Cockeysville Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Mr. Frank Smith</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 N. Park</u>	
DATE <u>March 16 1956</u>							

# WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18 1967 CERTIFICATE OF DEATH

FILE ONE-34

1. DEATH CERTIFICATE OF STATE OF ALABAMA

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. COLOR

6. CITY AND COUNTY

7. STATE

8. MARITAL STATUS

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. NAME OF PHYSICIAN

16. NAME OF HOSPITAL

17. NAME OF NURSE

18. NAME OF CORONER

19. NAME OF JURY

20. NAME OF WITNESSES

21. NAME OF FUNERAL HOME

22. NAME OF BURIAL PLACE

23. NAME OF CEMETERY

24. NAME OF INTERVIEWER

25. NAME OF INTERVIEWER

26. NAME OF INTERVIEWER

27. NAME OF INTERVIEWER

28. NAME OF INTERVIEWER

29. NAME OF INTERVIEWER

30. NAME OF INTERVIEWER

31. NAME OF INTERVIEWER

32. NAME OF INTERVIEWER

33. NAME OF INTERVIEWER

34. NAME OF INTERVIEWER

35. NAME OF INTERVIEWER

36. NAME OF INTERVIEWER

37. NAME OF INTERVIEWER

38. NAME OF INTERVIEWER

39. NAME OF INTERVIEWER

40. NAME OF INTERVIEWER

41. NAME OF INTERVIEWER

42. NAME OF INTERVIEWER

43. NAME OF INTERVIEWER

44. NAME OF INTERVIEWER

45. NAME OF INTERVIEWER

46. NAME OF INTERVIEWER

47. NAME OF INTERVIEWER

48. NAME OF INTERVIEWER

49. NAME OF INTERVIEWER

50. NAME OF INTERVIEWER

51. NAME OF INTERVIEWER

52. NAME OF INTERVIEWER

53. NAME OF INTERVIEWER

54. NAME OF INTERVIEWER

55. NAME OF INTERVIEWER

56. NAME OF INTERVIEWER

57. NAME OF INTERVIEWER

58. NAME OF INTERVIEWER

59. NAME OF INTERVIEWER

60. NAME OF INTERVIEWER

61. NAME OF INTERVIEWER

62. NAME OF INTERVIEWER

63. NAME OF INTERVIEWER

64. NAME OF INTERVIEWER

65. NAME OF INTERVIEWER

66. NAME OF INTERVIEWER

67. NAME OF INTERVIEWER

68. NAME OF INTERVIEWER

69. NAME OF INTERVIEWER

70. NAME OF INTERVIEWER

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75. NAME OF INTERVIEWER

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84. NAME OF INTERVIEWER

85. NAME OF INTERVIEWER

86. NAME OF INTERVIEWER

87. NAME OF INTERVIEWER

88. NAME OF INTERVIEWER

89. NAME OF INTERVIEWER

90. NAME OF INTERVIEWER

91. NAME OF INTERVIEWER

92. NAME OF INTERVIEWER

93. NAME OF INTERVIEWER

94. NAME OF INTERVIEWER

95. NAME OF INTERVIEWER

BUREAU V. S.

MAR 16 1956

RECEIVED

RECEIVED

RECEIVED

2518

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

COUNTY *Balto. 22.* MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) *Dundalk.* LENGTH OF STAY *life.*  
 OR TOWN  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS *8811 Wise Ave.*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Do.* COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town) *in*  
 OR TOWN  
 STREET ADDRESS (If rural, give location) *#1.*

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

*JOHN.**WIDRANSKY JR.*

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

*Mar. 18**1956*

## 5. SEX:

## 6. COLOR OR RACE

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

*Male**White**Single**Oct. 18, 1909**46 yrs.*

Months

Days

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

*no.**213-07-6323**Pete Binos.**address as in #1.*

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

*443x*

## Immediate cause

(a)

DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

*Myocardial Failure.**Hypertensive Cardiovascular disease 2 yrs.*

## INTERVAL BETWEEN ONSET AND DEATH

*6 hours.*

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

## PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan. 17, 1954* to *3/18, 1956*, that I last saw the deceasedlive on *3/18, 1956*, and that death occurred at *1:30 p.m.*, from the causes and on the date stated above.

## SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

*Louis N. Tollin M.D.**6908 North Pk Rd. Balto. 19.**3/18/56**DATE SIGNED**3/18/56*

## 23. BURIAL, CREMATION, REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

*BURIAL**3-21-56**SACRED HEART - MARY**BALTO. Co. Md**DATE SIGNED*

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

*March 20-1956**William M. Kelly**With Burke Bradley, Dundalk, Md.**DATE SIGNED*

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 22 1956

RECEIVED



CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>6 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1005 E. Belvedere</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HAL</b>		First <b>HAL</b>		Middle <b>H. WIGINGTON</b>		Last <b>HAL</b>	
4. DATE OF DEATH <b>March</b>		Month <b>March</b>		Day <b>8</b>		Year <b>19 56</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 8, 1897</b>	
9. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR Months <b>58</b>		IF UNDER 24 HRS. Days <b>58</b>		Hours <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Company</b>		11. BIRTHPLACE (State or foreign country) <b>Morristown, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Wigington</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Hensley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-12-9819</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE, AORTA</b> DUE TO <b>ARTERIOSCLEROSIS, AORTA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Proteus vulgaris septicemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 2</b> , 19 <b>56</b> , to <b>March 8</b> , 19 <b>56</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>3-8-56</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Cook-Blight, Inc</b>				24a. REC'D BY REGISTRAR <b>12 1956</b>			
ADDRESS <b>6009 Harford Rd. Balto. 11, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lurber</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MAR 12 1956

BUREAU V. S.

RECEIVED

02664

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2676

## CERTIFICATE OF DEATH

Reg. Dist. No. *45*

1. PLACE OF DEATH COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Edgemere</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Edgemere</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2538 Lyncamore Ave</i>		STREET ADDRESS (If rural, give location) <i>2538 Lyncamore Ave</i>	
3. NAME OF DECEASED (Type or Print) <i>Debra</i>	(First) <i>Debra</i>	(Middle) <i>M</i>	(Last) <i>Williams</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>-</i>	8. DATE OF BIRTH <i>July 5-1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Edgemere Md</i>
13. FATHER'S NAME <i>Elijah Johnson</i>		12. CITIZEN OF WHAT COUNTRY? <i>Md</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT AND ADDRESS <i>Debra Williams 2538 Lyncamore Ave</i>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 4<sup>th</sup>* 19*56*, to *March 6<sup>th</sup>* 19*56*, that I last saw the deceasedalive on *6<sup>th</sup> March 1956* and that death occurred at *5 P* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

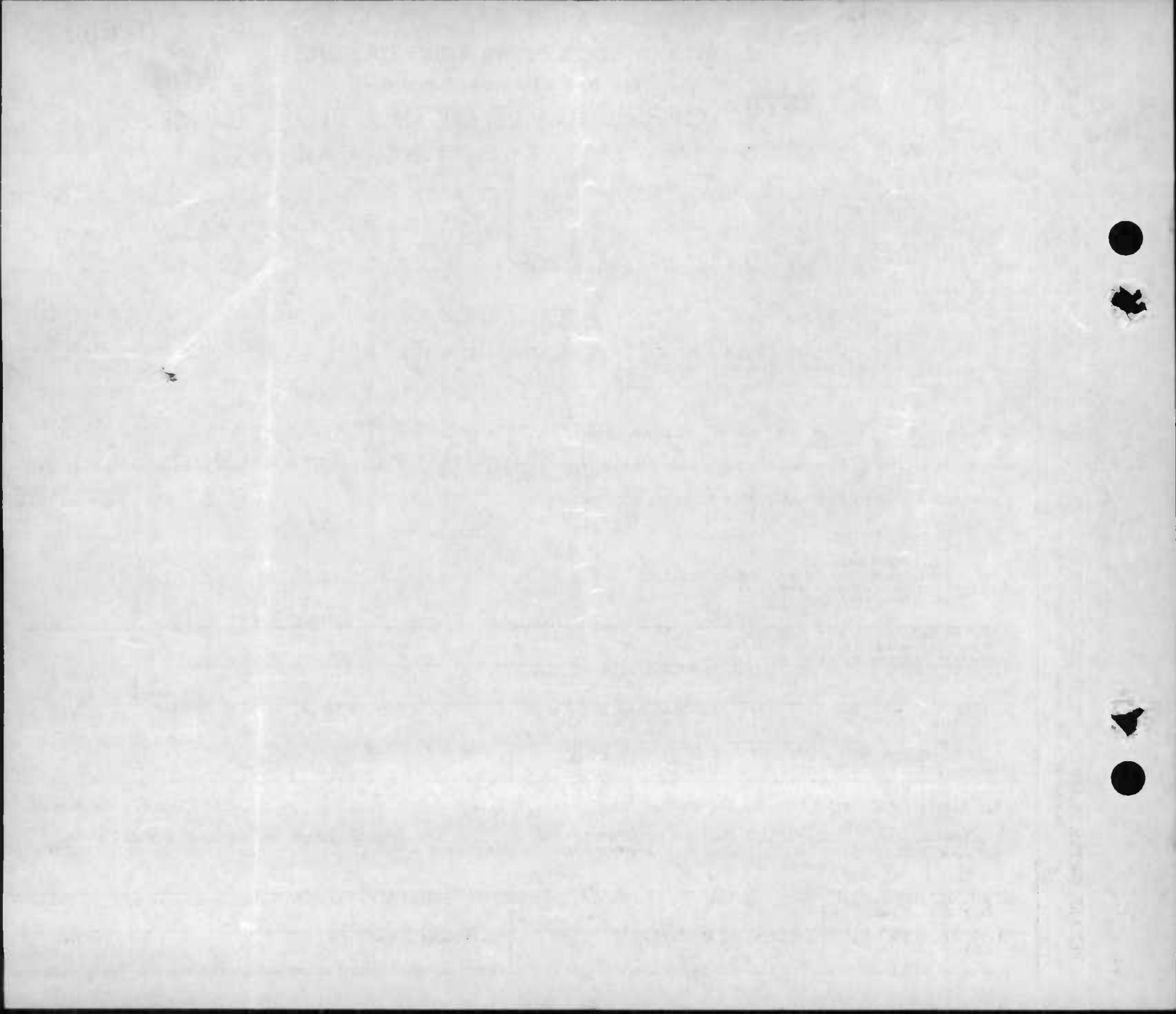
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2677

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>22 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 126 Rosewood Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>M</b> Last <b>WILMOTH</b>				4. DATE OF DEATH Month <b>March</b> Day <b>I</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24 1873</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Basil Iglehart</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Burns</b>			
15. WAS DECEASED ENER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>II II</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Loree I Wilmoth</b>		Address <b>53II Old Frederick Rd, ck</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis heart disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19 <b>36</b> , to <b>March 1, 19 56</b> , that I last saw the deceased alive on <b>Feb. 21, 19 56</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John H. Trescher</b> M.D. <b>1635 N. Calvert St</b> PHYSICIAN'S NAME (Type) <b>John H. Trescher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 3</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Upper Seneca Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Cedar Grove Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W Barber</b> <b>Francis H Barber</b>				ADDRESS <b>Laytonsville, Md</b>		24a. REC'D BY REGISTRAR <b>3/5/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>V.E. Harry</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-BALTIMORE-HEALTH DEPARTMENT STATE AND MARYLAND

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June 24 1978

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## Analysis

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BUREAU V. S.

MAR 7 1956

John H. Treachery

1991-1992

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02666

Reg. Dist. No.

2678

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>319 E <del>Street</del> - De Roy 53</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rheem MFG. Co.</u>		d. STREET ADDRESS <u>Dundalk</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE Henry Woolery</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-99</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rheem MFG. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Don't know</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> 1916-1924		16. SOCIAL SECURITY NO. <u>429-07-1544</u>	
17. INFORMANT <u>Rheem MFG Co</u> Address <u>Edgemere Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic H.D.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>16 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 20, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR <u>March 20, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Hurley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1956 MAR 20

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2679

## CERTIFICATE OF DEATH

02667

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville, 10 yrs</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broadway Rd.</b>				d. STREET ADDRESS <b>Broadway Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Albert</b> Last <b>Wright</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1956</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1873</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher, Youngstown Ohio, Ohio</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Wright</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Nr. Lutherville. Mrs. Finley Smith, Broadway Rd. Balto. Co.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Renal-Vascular disease with hypertension</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>January 19th, 1956</b> to <b>March 19, 1956</b> , that I last saw the deceased alive on <b>March 12, 1956</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rollin B. Hudson</b>				M.D. <b>606 Baltimore Ave Towson Md</b>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <b>3/19/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Mar. 2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lake Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Youngstown, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Wight</b>				ADDRESS <b>4101 EDMONDSON AVE</b>		24a. REC'D BY REGISTRAR <b>March 20, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Anne Mac Rary</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

MAR 22 1956

THE CHAIR

CERTIFICATE OF DEATH

Reg. Dist. No. 30

2680

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore City</b>
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>52 Catonsville</b>	LENGTH OF STAY (in this place) <b>6yrs 5mths 4dys</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore City</b> <b>3401-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>14 SPRING GROVE STATE HOSP.</b>	STREET ADDRESS (If rural give location) <b>1711 E. Lombard St. -Balto. 31</b>		
3. NAME OF DECEASED: (First) (Middle) (Last) <b>KATHERINE ZACHOW</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>March 4, 19 56</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>July 7, 1874</b>
9. AGE last birthday <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>embroidering</b>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
13. FATHER'S NAME: <b>Ludwig Karl Zackow</b>		14. MOTHER'S MAIDEN NAME: <b>Pauline Schmidt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>unknown</b>		18. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT & ADDRESS: <b>Records Spring Grove State Hospital</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage (Right)</b> DUE TO			
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) _____ DUE TO			
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept 30</b> , 19 <b>49</b> , to <b>March 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 4</b> , 19 <b>56</b> , and that death occurred at <b>345</b> P. M. from the causes and on the date stated above.			
SIGNATURE <b>J. P. Brown</b>		M. D. <b>Spring Grove Hospital</b> <b>3/4/56</b> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>3/7/56</b>	NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>	LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE REC'D BY LOCAL REGISTRAR <b>March 6, 1956</b>	REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>Paul H. Heyman</b> ADDRESS <b>6067 Hayford Rd</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02669

2681

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>36 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Reisterstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>Zepp</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1873</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Larkins</b>				14. MOTHER'S MAIDEN NAME <b>Sarah A. Frank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Joseph F. Zepp, Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C-V Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>none</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>11-9-39</b> , 19____, to <b>3-20-56</b> , 19____, that I last saw the deceased alive on <b>3-19-56</b> , 19____, and that death occurred at <b>12:30 A.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>D. D. Caples</b>				ADDRESS (Street, city or town, state) <b>6 Hanover Road</b>		DATE SIGNED <b>3-20-56</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nar. 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grace Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3-20-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	

BUREAU V. S.

MAR 22 1956

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF REGISTRATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2682

## CERTIFICATE OF DEATH

Reg. Dist. No.

02670

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Pikesville</u>	c. LENGTH OF STAY IN 1b <u>Lifetime</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>102 Church Lane</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Zimmer</u> Last <u>Zimmer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip H. Zimmer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Pick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. George Zimmer</u>		Address <u>Pikesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO <u>5415.</u> (c) <u>Diabetes mellitus</u> DUE TO <u>5415.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>55</u> , to <u>Mar 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>Pikesville, Md</u>	
DATE SIGNED <u>3/3/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. James A. Miller</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wm. H. Miller Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		ADDRESS <u>Pikesville</u>	
24a. REC'D BY REGISTRAR <u>DATE 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

CERTIFICATE OF DEATH

3683

03640

See title 187



RECEIVED

VS. A15

BUREAU V. S.

MAR 5 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02671

2683

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 12, Film G194 4-2-56 et

1. PLACE OF DEATH. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <b>Md.</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Catonsville,</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House in The Pines 16 Fusting Ave.</b>		STREET ADDRESS (If rural, give location) <b>6006 Glen Oak Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>Felicia Messina</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>24</b> (Year) <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widow</b>	8. DATE OF BIRTH <b>May 31, 1868</b>
9. AGE last birthday <b>87</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Salatore Messina</b>		14. MOTHER'S MAIDEN NAME <b>Dominica</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mr. Joseph P. Zito 4110 Milford Mill Road</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
HOMICIDE  
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?  
OF Not While  
INJURY Work ☐ At work ☐

22. I hereby certify that I attended the deceased from **2.13.56**, to **3.24.56**, that I last saw the deceased

alive on **3.21.56**, 19....., and that death occurred at **7.45** P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

**Harry S. Gumbel M.D.** 4605 Edmondson Ave. March 26, 1956

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
**Burial** **March 28, 1956** **New Cathedral** **Baltimore, Md.**

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
**3/27/56** **John O. Mitchell & Sons Inc. 1900 Eutaw Pl.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MADE IN MARYLAND FOR BINDING





02672

MARYLAND

STATE DEPARTMENT OF HEALTH

2684

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>313 South Collington Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ALBERT</u> <u>ZLOTKOWSKI</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>8</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 30, 1889</u> <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Extract Co.</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Poland</u> <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alexander A Zlotkowski</u>		14. MOTHER'S MAIDEN NAME <u>Lydia MN: Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY No. <u>212-10-0965</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
163X Immediate cause (a) <u>CARCINOMA OF LUNG</u>			UNKNOWN
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b).....			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c).....			
19a. DATE OF OPERATION <u>1/24/56</u>	19b. MAJOR FINDINGS OF OPERATION <u>Biopsy, lymph node, left axilla</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN)	(COUNTY) (STATE)
HOW DID INJURY OCCUR?			

22. I hereby certify that VA attended the deceased from Jan. 7, 1956, to March 8, 1956, and that death occurred at 12:40 p.m. from the causes and on the date stated above.

SIGNATURE Francis G. Dickey, M.D. Chief, Medical Service, VAH, FORT HOWARD, MARYLAND ADDRESS 3-8-56 DATE SIGNED 3-8-56

23. BURIAL, CREMATION, REMOVAL (Specify)  
Burial DATE March 13/56 NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery LOCATION (City, town, or county) (State)  
Baltimore 22, Maryland

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE A.W. Hedrich 24. FUNERAL DIRECTOR ADDRESS  
Fred W. Ozazewski Funeral Home  
1930 Eastern Ave., Baltimore, Maryland

MARGIN RESERVED FOR BINDING

